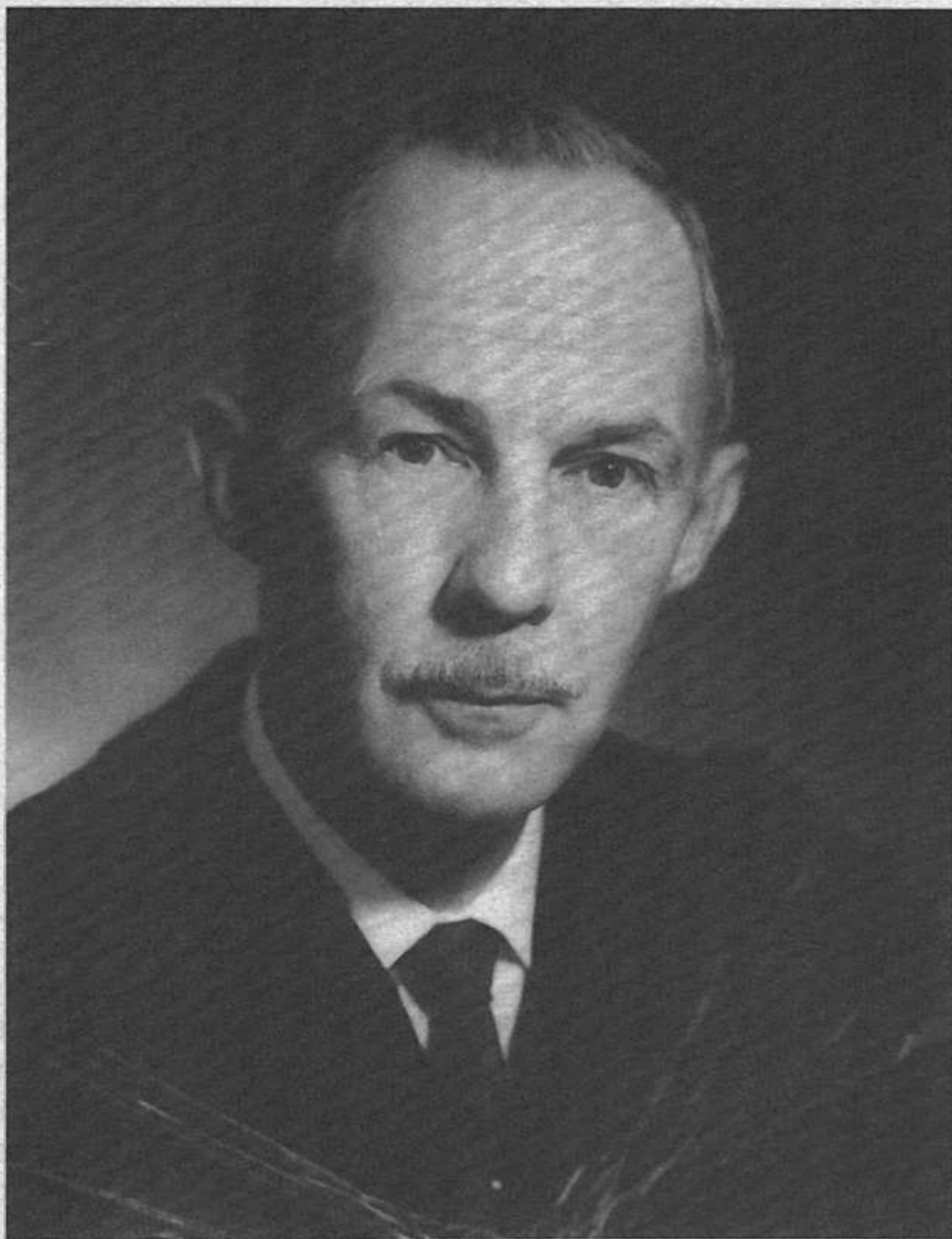


COUNCIL ON DIAGNOSIS AND INTERNAL DISORDERS
OF THE AMERICAN CHIROPRACTIC ASSOCIATION

THE CHIROPRACTIC FAMILY PHYSICIAN

NOVEMBER, 1980

VOL. 3 NO. 1



A. EARL HOMEWOOD, D.C.

"DYNAMICS of CORRECTION of ABNORMAL FUNCTION" TERRENCE J. BENNETT LECTURES

EDITED AND PUBLISHED

By

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the Chiropractic FAMILY PHYSICIAN

NOVEMBER, 1980

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PRESIDENT'S PAGE

E.A. Wilson, D.C.

To be a member of the council on Diagnosis and Internal Disorders is to be a member of the great future of Chiropractic and you may rest assured that Chiropractic has an astounding and unbelievable future. What we see as impossible today will be common place tomorrow. The doctors of the 21st century will not be able to believe the history of Chiropractic as it is now unfolding.

It is my honest and whole hearted opinion that this council is going to play more than a passive part in bringing this about as is being shown by those who dropped out for various reasons but are now being re-instated at a steady pace.

The Chiropractic Family Physician with its practice tips and diagnostic information is playing a big part in this upswing. Most of our authors are giving you the benefits of their years of practice and will continue to do so. Please share your health tips with us. Such small things as an impacted ear can keep you from correcting torticollis.

A TRIBUTE TO A. EARL HOMEWOOD, D.C., LL.B., F.I.C.C.

Dr. Homewood represents the enigma of greatness. He is a man who speaks profound truths with such innocence and quiet certainty, with such mildness and humility that only later do his listeners realize the real depth and wisdom of his statement.

As an instructor in neurology and chiropractic principles and technic Dr. Homewood always met the first requirement . . . he knew his subject. Probably there are very few in chiropractic history who have delved so deeply in the subject of neurology and then with equal depth related the subject to the expertise of manipulation and adjusting of the articulations of the body. Also no writer and researcher in chiropractic has done more to establish purely scientific basics for the principles and practice of chiropractic.

In Dr. Homewood's recent book, "The Neurodynamics of the Vertebral Subluxation," Dr. Herman S. Swartz states in the Introduction with astute accuracy, "Dr. Homewood is a most gifted writer. He turned his deep concern for the recognition of chiropractic by the intelligent doctor, student and public opinion makers into a grueling and deliberate task of explaining the complications of the subluxation in an interesting and scientific manner. His appreciation for the achievements of chiropractic caused him to dig deep into the biological sciences for verification."

Dr. Homewood's educational background:

Bloor Collegiate Institute, Toronto, 1936
Shaw's Business College, Toronto, 1937
University of Natural Healing Arts, Denver, 1941
Western States Chiropractic College, Portland, 1942
Philadelphia College of Naturopathy, 1952
Blackstone School of Law, Chicago, 1960

(Continued on page 23)

EDITORIAL

"Patient Control"

by

Richard H. Tyler, D.C.

Not long ago a young lady called for an appointment. She made it quite plain that it was not for any kind of treatment. "I simply want to ask some questions," she stated. The appointment was made and when she arrived we went directly into my office for consultation. Her problem apparently wasn't whether she should have chiropractic care but for how long. The chiropractor she had been going to had adjusted her once and then told her that it would take twenty-seven more treatments before she would be well. "He didn't say that you might be well on the twenty-sixth visit or even the twenty-eighth?" I asked, "No," she smiled, "it was twenty-seven. That's why I came here. I just wanted to know if it was possible for anyone to predict the number of times it takes to get results." I, of course, told her that it was impossible for anyone to do so much less guarantee that they would **ever** be able to get satisfactory results. To compound the matter even more the doctor's examination had been a cursory one of little or no dimension.

More often lately you hear about these "special plans" that every patient just **has** to have if they are to get well. Health sold by the yard all under the guise of "patient control." The get rich quick boys have hit upon this scheme of selling health packaged by the numbers. This is a complete denial of physiological truth. No one on this earth can tell anyone else how they will react to any kind of health care much less tell them the amount of time required for optimum results. This is deceit unworthy of our profession.

For those preoccupied with patient control just to make a buck there is no reasoning. They are charlatans and their die is cast. For those who wish patient control, however, because they honestly feel that this will benefit the patient, the answer is not some glib set of guaranteed numbers but control built solely upon trust and actual patient need. While both requisites are important the trust cannot come unless the need is demonstrated in a positive and forceful manner.

The well trained chiropractic family physician demonstrates his qualifications with the initial examination. The patient will soon realize by the very scope of what he does and the questions he asks that he is more than qualified to treat the areas he examines. The more areas examined in depth the more the patient is impressed that the doctor possesses the knowledge and training to treat what he may observe. If you examine the tonsils and tell that patient they are inflamed they will usually ask what may be done. When you tell them of digital massage under a topical anesthetic, followed by ultra violet radiation and a gargle their confidence in you is reinforced. It won't be long before the patient realizes that you are a fully qualified physician not just a "back cracker" or glorified masseur out to sell you some kind of phony health package.

We are at a turning point in our profession. We can be the door to door salesman of the healing arts or we can be the portal of entry into complete health care that will be more productive than any other branch of the healing arts. You may not make the same amount of money as the pitchmen but you'll be comfortable and what is more you'll be able to look at yourself in the mirror without cringing. □

TO ADJUST OR NOT!

A.E. Homewood, D.C.
Western States Chiropractic College

A letter, written by Dr. Willem J. Kruger, Jr., appearing in both the A.C.A. Journal and The Chiropractic Family Physician, sparked a few thoughts that may be worthy of sharing.

Iatrogenic disease, as a result of prescribed drugs, is epidemic in proportion and is not only dependent upon the abuse of these pharmaceuticals, but upon their use. The allopath is almost completely dependent upon this form of therapy with results that are less than satisfactory. In the words of Spain¹, "Unfortunately, therefore, iatrogenic disease can now take its place almost as an equal alongside the bacteria as an important factor in the pathogenesis of human illness."

Moser² stated, "... we have reached a point in medical history when we must reappraise the status of drugs and patients."

In his facetiously written book Dr. Mendelsohn³ combines opinion, amusement, and heart-breaking facts, stating in his introduction, "I believe that Modern Medicine's treatments for disease are seldom effective, and that they're often more dangerous than the diseases they're designed to treat."

That renowned researcher and writer, René J. Dubos⁴, was quoted by Spain as writing, "... and who could have dreamt a generation ago ... that patients with all forms of iatrogenic diseases would occupy such a large number of beds in the modern hospital?"

Spain⁵ was more specific in his assessment of the problem, "in one large general hospital at any given moment, 50 out of 1000 beds are constantly occupied by the complications of these chemotherapeutic agents. This does not account for the beds occupied as a consequence of the complications from diagnostic and therapeutic instrumentation."

Gross⁶, reporting on surveys done by Yale-New Haven Hospital and others, extrapolated the figures of 200,000 deaths and 5% of the 28,000,000 hospital admissions per annum as the result of prescribed drugs.

Such distressing facts should convince the skeptics that the public is entitled to the opportunity to have a manipulative and applied neurological approach utilized for their health problems prior to being subjected to the iatrogenic risk of allopathic medicine. There is no hint of a suggestion that such a number of patients had ever died or been hospitalized in the entire history of chiropractic ministrations, or, for that matter, as the result of all the forms of manipulation over all the generations of their use. It would appear that there are not facts available to indicate that patients are placed at risk by unwarranted structural manipulation. The chief argument for not providing manipulation seems to be that they may be delayed in seeking the iatrogenic risk of allopathic medicine.

The suggestion that patients may be receiving unnecessary chiropractic care may be a point well taken, but there is no indication that their health is at risk from the

experience. On the other hand, if we accept D.D. Palmer's⁷ assessment of the cause of subluxation as, "traumatism, poisons and auto-suggestion," or in more modernized terms, "internal or external environmental stress of a mechanical, chemical and/or psychological nature," the periodic assessment of structure and corrective adjusting may be indicated. If, however, it is held that a patient must have experienced a severe mechanical insult, such as a fall or being hit by a Mack truck, then such examination and adjusting may be unwarranted.

The stresses of life would seem to have expanded drastically since the days of D.D. The car, industry, and other mechanical stressors, unknown in his time, have been compounded by the lack of exercise and excessive time spent in overstuffed furniture to the detriment of physical structure. Nor were D.D. and his generation subjected to the chemical irritants of processed foods, respiratory, chemical irritants, etc., and the expansion of the psychological stressors to encompass the trials and tribulations of the world via T.V. coverage which now brings war into our living rooms. Each of these, and in combination, make for a form of cause that is universal and impossible to escape in "normal" civilization.

In the words of Wardwell⁸, "SMT (Spinal Manipulative Therapy) on a regular prophylactic basis has been advocated as a means by which a healthy person can become even healthier. Although the practitioners of prophylactic SMT have sometimes been charged with giving excessive and unnecessary treatment, a real possibility exists that such use, along with other natural healing methods, will result in better overall health."

An English allopathic physician, Dr. Paul Sherwood⁹, has concluded that most heart attacks are the result of coronary artery spasm, rather than occlusion by atheromatous plaques, and suggest that the cause is congestion around the stellate ganglion. His treatment of choice is ultrasound, Faradic current, massage, and gentle manipulation. On the basis of the effects of mechanical, psychological, and chemical irritation upon the cervicothoracic region with attendant hypertension of the musculature, periodic assessment and adjusting might prove to be worthy prophylaxis for the prevention of coronary spasm, sudden death or myocardial infarction.

The use of the immunization program by the allopaths has been based upon the supposition of prophylaxis and when the disease does develop in a "protected" individual, the answer is, "but think of how much worse the disease would have been, if you had not been immunized." This is a safe "heads I win, tails you lose" type of bet and could be applied equally well as an argument for prophylactic chiropractic adjustive care.

Dentistry has educated the population to the semi-annual examination and, with the advent of the dental hygienist, has developed a thorough cleaning of the teeth as an added feature. Surely the human frame with its multitude of ligaments, muscles, joint capsules, and intimate relationship to the neural system is as deserving of periodic assessment as the thirty-two, or less, teeth.

Allopathic medicine has attempted to sell the annual physical examination as a

prophylactic measure, but has begun to back away from the embarrassment of not being able to diagnose developing conditions until frank symptoms and tissue changes appear.

The many and varied environmental irritations to which all are subjected, result in myotonic hypertension with alteration of articular movement. The actual site of subluxation may be predetermined by many factors, either solo or in concert, e.g., hereditary weaknesses, asymmetries, anomalies, etc.; postural faults; asymmetrical muscle development, due to occupation or recreation; the canalization or facilitation of neural pathways resulting from prior injuries or subluxations, which predispose to recurrence; etc., etc.¹⁰ It would be most unusual to examine a person without being able to determine a subluxation or structural dysfunction. Many of these may well be self-correcting with rest, recreation, or a fortuitous twist or movement that balances the myotonic variance.

Arguments may be raised in objection to adjusting a normal articulation, but does it do any harm to move an articulation, either actively or passively, in the direction in which it is constructed to move? On the other side of the coin, any force exerted upon any articulation that attempts motion along an incorrect vector is detrimental and produces noxious neural impulses.

It is regrettable that experience necessitates the admission that many thrusts are delivered incorrectly and are maladjustings, rather than adjustings. There is no way that exact direction can be translated from palpation or x-ray findings to the actual delivery of a correctly directed thrust which embodies the exact line of need, speed, depth, and force. Many forget that the spine is a three dimensional organism, requiring consideration of the subluxation's position in relation to the apex of the kyphosis or lordosis of which it is an integral part; also, whether the contact is being taken on the convex or concave side of a scoliosis; and, whether the corrective force is required to primarily correct a rotation or a laterality. The factor of speed of release to utilize the elastic recoil of the tissues to aid in raising a lordosis, or the prevention of this "bouncing back" of an area of kyphosis after the depth of thrust has been instantly released, is another consideration that should be embodied in any thrust. More concern is deserved for the artistry of adjusting, rather than the frequency.

Grave solicitude is experienced for the patient, especially myself, when a cervical "adjusting" is observed, or experienced, when the doctor has merely palpated or read the x-ray, then picked up the head and delivered a twisting thrust without having assessed the proprioceptive feedback from the tissues, which provide the information as to location of the centering of force, the degree of force required, the degree of relaxation of the tissues, etc. If the patient is fortunate, a 'sound' effect satisfies the doctor and no further force is delivered at that site. In other instances, the head and neck are rotated, much like taking the top off a jar, until the patient's neck "pops", or he rolls off on the floor. Again there has been no "feeling," or sensing, by proprioceptive feedback of the actual site, or level, where the force will be concentrated and no determination of whether the thrust will be a pure, unadulterated rotatory move, or the degree of laterality that is being introduced into a rotatory-break. In many instances serious doubt arises as to whether the doctor is cognizant of whether his contact is on the convex or concave side of a scoliosis.

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HOLISTIC PRACTICE — THE NEED FOR EARLY DIAGNOSIS

by William A. Nelson, D.C.

Holism recognizes that the determining factors in living nature are irreducible wholes. As simple as it sounds in definition, it is a very difficult concept to grasp for most people. We have been conditioned for many decades that sickness is a limited thing. We take for granted that a heart attack involves only the heart, that a boil is only a local problem and that an ingrown toenail is certainly nothing other than a problem with a toe. By the true concept of the holistic approach, everything involves everything else, to a greater or lesser extent.

People of the Orient do not have as much trouble accepting this view because they have been trained to think in a circular or encompassing direction. Our western culture tends to look at problems in a linear manner. Acupuncture, when first introduced to the West, became a panacea for most of the ills of man. The Orient knew it to be but one approach to a total healing attempt and to be used in conjunction with other remedies, not by itself.

Many holistic centers are mainly aggregations of specialists where it is assumed that by looking at the patient through many eyes the whole person will be seen. In reality, as with the blind child studying the elephant, only the part or parts of the specialty will come under serious scrutiny. Thus no one has really seen and studied the whole patient, instead the patient has been viewed as a group of related parts wherein the relation between the parts is uncertain. This becomes an example of where the increasing of knowledge diminishes the understanding.

The holistic practitioner must be a generalist in the true sense of the word. He must have the skill of the old time family doctor who had to arrive at a diagnosis without the sophisticated machinery available today to the average doctor. The art of healing must be emphasized over technical competence in the case of the holistic practitioner. The laboratory, the electronic equipment and the hospital must all come after a tentative diagnosis has been made. Otherwise the selected tests assume too much importance and tend to warp a complete and in-depth understanding of the whole person.

A major disadvantage of the fine equipment available today is that it measures the individual against a normal. In the holistic context the individual is recognized as just that, an individual different from every other individual. Thus, we can not measure a person against another who is different. The idea of normal or average values can not be taken too seriously in a holistic practice. This, too, will tend to turn some people off as our whole health program is predicated on normals against whom the rest of us are measured.

The secret to an improved holistic approach is simple. It was promulgated by the founder of chiropractic, Dr. Daniel David Palmer, who said, "Tone is the basic principle". Tone is the normal degree of vigor and tension in any particular tissue of the body and normal tone represents functional health. The idea of using tone as a diagnostic tool is found largely within the chiropractic profession. All schools use tone to some extent but the chiropractor uses it to an ex-

(Continued on page 10)

treme degree, in the opinion of others. Actually, it gives the chiropractor an opportunity to detect conditions long before they are recognizable by any other means. The earlier a diagnosis can be made, the better for the patient. Early recognition of the disease process will usually identify the systems of the body involved and make appropriate therapy more effective.

Human nature is prone to take the shortest route between two points. The holistic doctor can not do this. He must make a circumspect appraisal of the patient from head to toe and regard every symptom complained of in addition to provoking by adroit questioning recall of the ones the patient has forgotten. The doctor must review the diet, the home environment and the situation at the work place. In short, the entire environment of the patient must be taken into account to the greatest extent possible. This is no mean task and requires non-specialized training.

The tendency to a short cut is seen in the emphasis on nutrition by many holistic centers. Diet is truly holistic in its affects on the body but it is not the only influence for good or ill. When emphasizing diet the patient is often reminded that he is only what he eats. This, of course, is not true; you are not what you eat, you are what you assimilate. A far different matter.

Should the diet be ill suited for the particular individual's digestive capacity, abnormal tone will be the result. As soon as the physician has corrected the diet or improved the digestion, the tone comes back to normal. Here, too, the patient is measured against himself and not against an average.

In the ontogenological development of life, the need for an intercommunication system developed as the organism became more complex with specialized groups of cells. The first nervous system merely controlled the diameter of the small developing bloodvessels, the microcirculation, and has been aptly named the vasomotor system. While the original function of the vasomotors, that of varying tissue circulation as needed, is still maintained, developing organisms required better control over their more complex systems. Some controls needed to be voluntary such as locomotion and others were better entrusted to largely automatic control such as digestion or respiration.

The voluntary nervous system in man is the cerebrospinal that permits voluntary moving of the appendages, i.e., arms, legs and head. The involuntary or autonomic system is made up of three systems, sympathetic, parasympathetic and the vasomotor; the first two are mutually antagonistic. The sympathetic group tends to prepare the body for defense, viz., dilating the pupil of the eye, slowing or stopping digestion and activating the adrenal glands. The opposing parasympathetic system is usually concerned with repair and maintenance of the body as by activating digestion and contracting the pupil.

The nervous system, both voluntary and involuntary, is pretty well understood and mapped out except for the vasomotors. At the present time the vasomotors can not be dissected, the fibers are too short as they traverse the small bloodvessels, so our knowledge is empirical. It is believed the vasomotor system is responsible for the balance between the two great involuntary chains, the sympathetic and parasympathetic.

The ability to adapt to its environment is necessary for the health of an organism. The process of adaptation is a primary responsibility of the well functioning nervous systems and the execution is accomplished at the tissue level by the vasomotors, remembering that the vasomotors control the micro-circulation.

Ours is still a jungle nervous system and is not adapted for the complexity of modern life. The many and heavy stresses placed upon us are often too much for our primitive nervous system to handle. In such cases the imbalance between the sympathetics and parasympathetics cannot be overcome by the vasomotors. The night's sleep is not sufficient to restore nervous balance and problems develop. Tissue function goes awry. At first the nervous irritability is expressed in small ways, a simple cold sore, a slight headache or perhaps a mild constipation. If the body cannot quickly restore its nervous homeostasis the problems become more noticeable ways. It must not be forgotten that even in the beginning the whole body is affected although the only apparent manifestation might be the cold sore or the headache.

In the cold sore stage, for example, one might wonder at the whole body being involved. The usual diagnostic techniques will not reveal anything wrong. The patient can have as complete a physical examination as possible and frequently the report is negative, the patient is completely healthy; an absurdity in view of the presence of the cold sore. The answer is that the diagnostic techniques were not adequate to detect mild functional aberrations. A properly trained physician would have recognized areas of abnormal tone; the body does not lie.

The old time family doctor and the early chiropractors used tone to a great extent. Years ago the sophisticated equipment wasn't available and the early chiropractor didn't have access to a hospital or Xray equipment. Today the easy accessibility of electronic equipment encourages the physician, allopathic or chiropractic, to forego the use of sensory skills in favor of more tangible evidence of sickness. The difficulty here is that the first evidences of malfunction are being missed.

The first use of tone by the chiropractor was along the paraspinal muscles. Being concerned with the nervous system and its relation to the spine, the chiropractor used the muscles and their tension along the spinal column to give him a clue where trouble might exist. This was an excellent diagnostic tool and gave the early chiropractic physician a decided advantage over the allopath. The chiropractor could recognize and correct functional troubles that the allopath could not realize existed even though the patient was suffering. It was this that largely contributed to the growth of this profession in spite of strong medical opposition.

Today the chiropractic physicians have improved their diagnostic techniques. In addition to paraspinal muscle tone, they use kinesiology or Neurovascular Dynamics, both devoted to measuring tone. Kinesiology measures the tone of long or round muscles and Neurovascular Dynamics uses the tone of flat mus-

(Continued on page 23)

A MEDICAL VIEW OF CHIROPRACTIC

by
Leo E. Montenegro, D.C.

In the August 1980 issue of the Journal of the American Chiropractic Association, at page 51, there is an article by George A. Silver, M.D., a professor from the Yale School of Medicine.

The article contains the paradigm set for the Chiropractic profession by the Medics.

The first point made is that the Chiropractic profession sees itself "as an integrated healing system" and "outside the theoretical structure of medicine altogether."

The second point is to strongly imply that Chiropractic is unscientific but is gaining in public acceptance and must be viewed on a sociological basis.

The heart of the article lies in the following statement, "Most physicians are bitterly opposed to Chiropractic and would, if they could, bar the practice or, at the very least, forbid any public purse reimbursements."

"Since, it claims to be an alternative system of primary health care . . . it is up to the chiropractors to demonstrate that their theories are sound."

"Reiman's defile like Allens, signals the danger to the medical profession of losing out in the public policy struggles. The AMA yielded before the Federal Trade Commission and the chiropractors' threats of legal action. Blumenthal writing in the New York Times, points out that there are 'multibillion dollar stakes' in recognition, in view of the approaching(?) national health insurance program". . . 'Our leaders let us all down,' grumbles a radiologist. 'Never before in the history of organized medicine have so many physicians voted for something they knew was wrong.'"

"The policy issue will be, not whether chiropractic should be reimbursable, but under what conditions". . . "It will be necessary to consider the inclusion of chiropractic in a national health program despite recognition of the potential dangers in the therapeutic modality of the unorthodox paradigm, danger long appreciated and very real". . . "The status and recognized position in the health care system will serve as a conservative force and along with other factors serve to limit the scope of chiropractic services". . . "The demands of the legislation and insurance companies for precise definitions will serve further to limit the activities of chiropractors."

The limiting of the professional activities of Chiropractors is well on its way in California. An Attorney General Opinion released in May 1980 and accepted by the State Board of Chiropractic Examiners in June 1980 lays the groundwork to eliminate all drugless therapy and natural methods with the exception of adjusting the joints of the body as a definition for Chiropractic.

Many straights and Chiropractic Orthopaedists seem eager to limit Chiropractic practice as a medical manipulative specialty which would then mean, of course, that Chiropractic would be a tertiary health system and not a primary health provider.

It is obvious that the paradigm suggested by the medics for the Doctor of Chiropractic would not only limit scope of practice but would also limit services which would be eligible for payment under any insurance program. □

LETTERS TO THE EDITOR

Dear Editor:

Enclosed is \$25.00 for this years dues to your Council. I was a student member of your council last year and I have the highest praise for what the CDID is doing. As soon as The Chiropractic Family Physician arrives in the mail I can't help but read it cover to cover. I especially enjoy reading and learning much from Dr. Richard Tyler.

I will also be sending to Doctor Martin for his "Dynamics of Correction of Abnormal Functions."

I am in the process of joining the ACA as a 1st year doctor.

Thank you very much. Keep up the good work.

Sincerely yours,
Stephen R. Summeg, D.C.

Dear Dr. Tyler:

Outstanding article by Andy Jessen in your September issue.

I was so proud that a member of my profession wrote it that I sent it to the owner of a group of Laboratories in and around Fresno.

I'm sure it will significantly add to his already favorable view of Chiropractic.

Thank you,
Dave Barber, D.C.
Fresno, California

Dear Cynthia:

I can't tell you how pleased I was to read the *terrific* tribute to you that appeared in the September 1980 C.F.P.!! It was really a first: the first time any woman chiropractor has been straight-forwardly praised. You've done wonderful things for the profession, and just as importantly as far as I'm concerned, you've made the profession look seriously at women in the field. I, for one, appreciate it.

With best regards for your continued success.

Yours truly,
Beth Gruber, D.C.
Long Beach, California

Dear Editor:

Please take my name off your mailing list. I have no use for Chiropractoids! To bad you people didn't become Medics, where you belong!

Clarence D. Jenson, D.C.
Sacramento, California

Clinical Roundtable CASE HISTORY REPORT

by
Robert J. Wiehe, D.C.

I would like to submit a brief summary of a very interesting case of cirrhosis of the liver treated in our office.

Patient, M— B. C—, first came to our office June 30, 1978.

HISTORY: Patient had been seen locally by three medical physicians and referred then to an Internist in Springfield, Illinois.

MEDICAL DIAGNOSIS: Cirrhosis of the liver. Bilirubin tests were 12 times the normal test value. Patient had been told by these medical doctors that she would probably die within ninety days and that there was no known medical treatment for cirrhosis of the liver. Patient was advised by her medical doctor to return home and get her affairs in order.

PHYSICAL EXAMINATION: Patient was extremely jaundiced. Patient was also suffering several areas of eczema. Patient complained of extreme fatigue and malaise and nausea.

Patient was already on a liver disease diet. We instituted chiropractic adjustments, giving particular attention to the spinal autonomic nerve supply to the liver.

This patient began to make noticeable immediate improvement. Both the objective signs of jaundice began to disappear and the bilirubin tests began to improve.

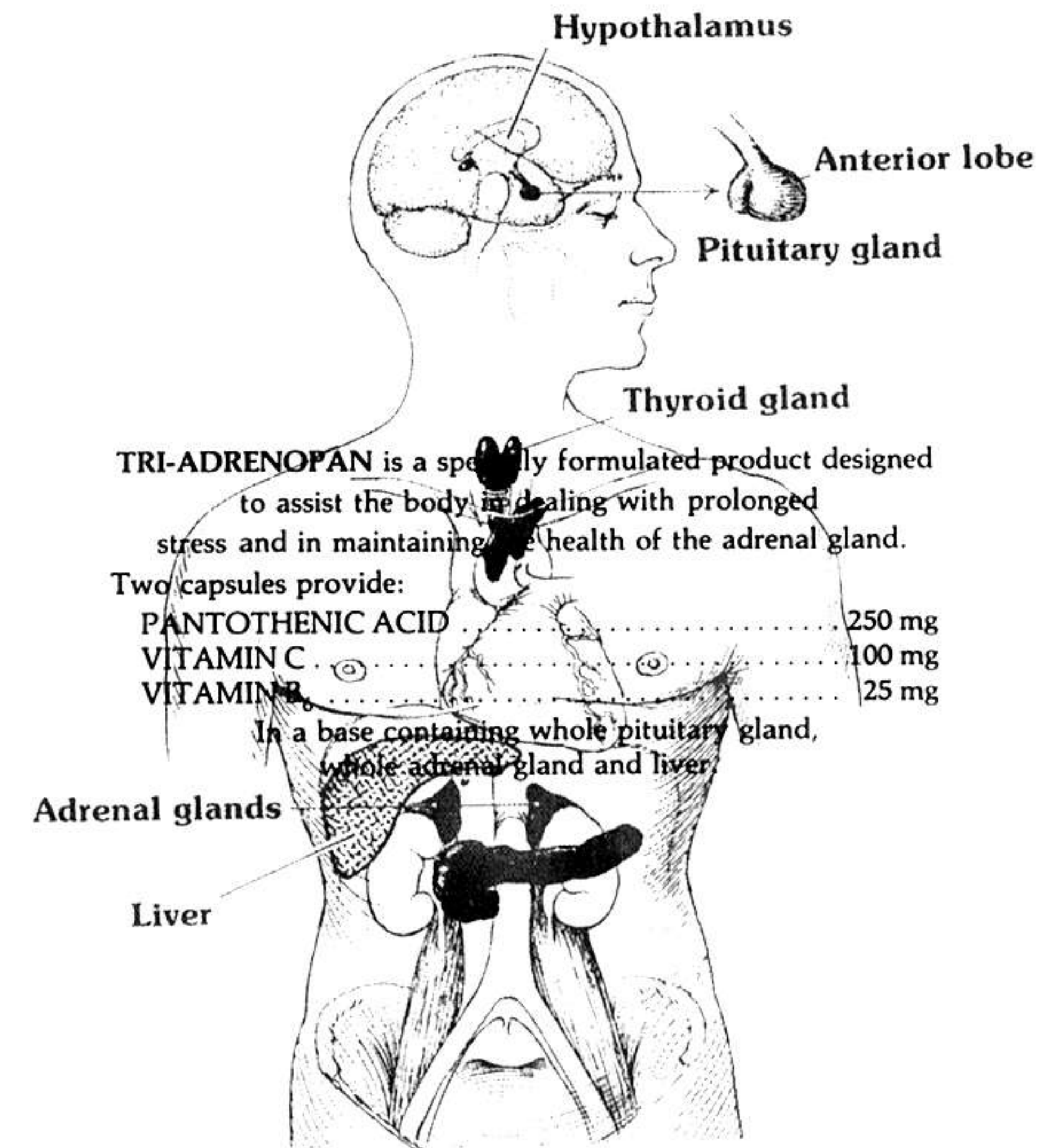
Simultaneously the patient's digestion improved and you could slowly see the jaundice fade away and natural color return.

Within six months all blood tests returned to normal.

The patient has been tested every three months since that date and the last blood tests show bilirubin to be exactly in the mid range of normal and, of course, the patient is still alive, having outlived the medical prediction of expiration in ninety days by two years.

Special Notation: Mrs. C— has informed that in a discussion with her Medical doctor, Dr. T—, he frankly told her that there was no question in his mind but that the Chiropractic treatment restored normal liver function and saved her life.

**WE ARE SADDENED TO ANNOUNCE
OUR PRESIDENT, DR. E.A. WILSON, D.C.
PASSED AWAY
OCTOBER 21, 1980**



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CHIROPRACTIC'S WEAKNESSES

by
Leonard D. Godwin, D.C.

Every profession has its strengths and its weaknesses; chiropractic is no different. The primary strength of chiropractic resides in the fact that it works, i.e., within the scope of its therapeutic parameters it gets sick people well and does so better than other therapeutic approaches. If this fact were not true, chiropractic would not have been able to survive 86 years of implacable hostility from medicine, the bad press it thus generated, the economic ups and downs of our society, and the pressures and vicissitudes that unsubstantiated quackery would have had to weather. Therefore, its very longevity is one of the strongest testimonies to its strengths and its effectiveness. A third strength of chiropractic is that it fulfills a definite need in the healing arts field, while a fourth strength is the dedication of present and past practitioners, pioneers really, who have fought for its very existence often at high personal cost, even to being sent to jail.

The weaknesses of chiropractic stem from the personalities and prejudices and, I'm sorry to say, the greed of some of its adherents; to this extent, the extent that human frailties abound in every profession, these weaknesses are not exceptional, though in chiropractic they definitely take on a unique manifestation. It has been a splendid experience for me to be a doctor of chiropractic and I would not trade that experience for anything. Nothing else I have engaged in has been as exciting and rewarding.

When I say 'rewarding,' I am not referring to the amount of money I have been able to earn as a chiropractor. In that respect I am merely an average chiropractor, not having found it necessary to dedicate myself solely to the pursuit of the almighty buck which would have interfered with some of the other things I am especially fond of doing, as for example, writing, painting, teaching, etc. I have no prejudice against those who make big bucks as long as they do the best job they can do on behalf of their patients. However, I do have a nagging feeling that those doctors who run through 60 to 90 patients per working day either have a large staff of nursing help to take away some of the duties or they are behaving like so many medical doctors: running cattle shoots. And cattle shoots, in my opinion, exist because the doctor is more interested in making money than in treating the whole person. Don't write nasty letters to me now telling me how you cry all the way to the bank, like Liberace, because of my "sour grapes" criticism. I hear these cattle shootists at seminars, standing around at the breaks bragging about how much money they're making. I also remember listening to some of the biggest cheats in my chiropractic school days standing around during the coffee breaks bragging about their high grades on this or that test. A cheat is a cheat is a cheat whether he is cheating on an examination or cheating a patient or an insurance company and our profession. Which brings me to my list of the gravest weaknesses in chiropractic:

- (1) Chiropractic has utterly failed to present to the public a viable health care alternative to destructive medicine.
- (2) The continuing internal "war" between the so-called "straights" and "mixers"

has done more damage to and retarded the growth of the profession into a powerful, unified healing system than all of medicine's hostility over the years.

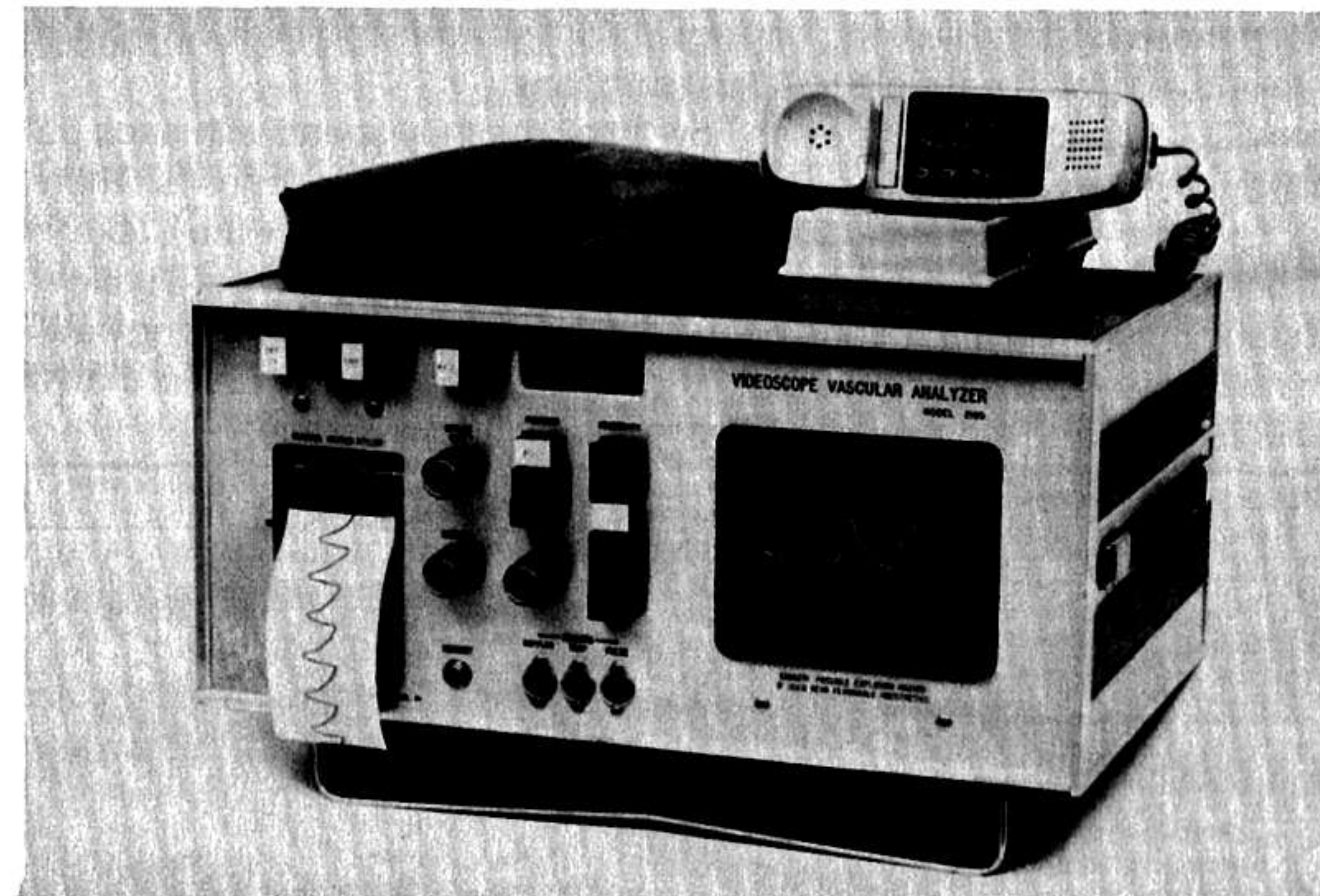
- (3) A serious weakness has been the almost disdainful regard for any type of real effort at true scientific research; after 86 years the profession has failed to produce much in the way of valid research, except a super-abundance of talk.
- (4) The amazing susceptibility of segments of the profession to untested gadgets, exotic notions, weird theories — anything but the one thing that consistently works on the behalf of patients — spinal manipulation.
- (5) The rampant, unchecked proliferation of "seminars" by self-anointed "authorities" that continually flush through the profession year after dreary year; the one thing these con artists have in common is the realization that the fees for these shallow rehashes of diseased "ideas" must be exorbitant enough to attract the suckers; showmanship, they know, sells and convinces, especially if they can hold out a promise to double the doctor's income — minus, of course, the cost of the "seminar."
- (6) The splintering off of the profession into a dozen or more different "schools" of technique (sometimes spelled "technic"), each with its band of die-hard subscribers giving the hard sell to patients — who, by the way, are only confused by this nonsense.
- (7) The pathetically low standards of privately-owned chiropractic colleges which somehow manage to persist despite lack of accreditation is a weakness.
- (8) The lack of disciplinary powers of the various state boards; the medical boards have the power to discipline but seldom use it, which is one kind of abuse, while we have the desire to clean up our deviates and can't, which is merely weakness.
- (9) The abysmally low quality of relicensing seminars (a good idea but one that has never justified its existence). I recently sat through a two hour "lecture" on the wonderful health benefits that are supposed to follow a system of adjusting the bones of the cranium, illustrated by the "lecturer" by means of a rubber skull(!!!), but he was forbidden to answer any of our questions because he was "sworn to secrecy" by the "society." Ye Immortal Gods and Horse Manure!!! Imagine that: he couldn't tell us any particulars at a relicensing seminar about the techniques of adjusting the skull, which entire subject matter borders on science-fiction penned by schizophrenics in the first place, because he had taken an oath of silence on the subject, YET HE PRETENDED TO BE LECTURING ON THE SUBJECT! Never has my gag reflex been so severely tested. This kind of asinine nonsense doesn't even qualify as first grade quackery, in my opinion. How would you like to attend a seminar where you are told that by placing a vitamin tablet on the patient's abdomen (belly — for the quacks) and pushing his arms down will tell the "doctor" whether or not that patient has a vitamin deficiency? Some doctors of chiropractic did and paid for this "information" to boot! The profession has survived despite this pukey idiocy, but it certainly leaves me in a cold sweat to be identified with it in the public mind.
- (10) One of the major weaknesses, a sword really, hanging over the profession are those doctors who excessively overtreat their patients for a variety of questionable "reasons:"

- a- Some insist, and do so eloquently, that they can orthopedically "straighten spines" with manipulation plus the use of orthotic heel and sole lifts; this is a peculiar form of self-delusion (or patient-delusion) that some chiropractors "sell" themselves (to be charitable) and their patients — that they can take a 45 year old skeleton with all its tendinous and ligamentous attachments and actually correct anatomic scolioses with 40 to 100 treatments. These "spine straighteners" have great contempt for other D.C.'s who only, in their words, "chase symptoms," while they "treat causes." By the time this lucrative scam has run its course and the insurance companies wake up and decide to stop financing this hooey, these "spine straighteners" will have retired in wealth and the rest of us will be left holding the empty bag. Another example of the con artist getting in and getting out scot free and to hell with the profession.
- b- Some "sell" patients on a long course of "maintenance" treatments to "prevent" the development of major diseases down the line (sometimes on a contract basis with a discount every tenth treatment), but insofar as I have been able to determine none of the "disease preventers" even conduct any kind of serious follow-up studies on such patients 5 and 10 years down the line; some of the Full Spine boys do take Comparative APFS's but it has been my experience that they too often use these as selling ploys to get even more treatments out of the patient. When I asked one of these salesmen once, "What do you tell the patient when you take the comparative APFS and the film shows no remarkable correction of the spine?" "Well," he said without batting an eyelid, "then, despite the fact the patient has been feeling good for the last few weeks of treatment I really have to look for all the little changes on the last film and emphasize that he must be one of those who is slow to heal and try to get him to go for another course of treatments." "But," I persisted, "what if the second comparative full spine view still doesn't show much improvement? Then, what do you tell the patient?" "Simple," he tells me without batting the same eyelid again, "I tell him that I'm sure he is now perfectly straight and therefore I think it best not to take another X-ray of his spine at this time to save him possible radiation damage." What kind of name would you put on this type of "doctoring?" We know what the M.D. would call it, don't we?
- c- Some sell fear of the dire consequences of not having regular chiropractic treatments. Don't, please, misunderstand me on this point. I myself have regular chiropractic care because I need it and I feel much better when I do and much worse when I don't. but after 17 years of adjustments I still have my original scoliosis, even after 3 years of continuous wearing of a 5 mm. heel lift which my spine has now become dependent on that I can't go long without it. Incidentally, I am constantly picking up patients who have gone through some of these "long schedules" of treatments without results. Recently, a lady on Medicare came to me hurting. The doctor of chiropractic she had been treated by following an automobile accident (P/I Case, not Medicare) has finished his 30 to 40 treatments, filed his narrative report and collected his big fee. A month after he had dismissed her from care, some of her original complaints returned. She presented to that doctor. Now, no

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- longer a lucrative P/I Case, she was told that he didn't accept Medicare cases!! He and his ilk make me blush for shame.
- (11) Some techniques used by doctors of chiropractic are inexcusably brutal. I have had several patients with severe whiplash conditions who had been treated by one of these brutal adjusters, having, I believed, jammed their cervical vertebrae into almost impossible to adjust positions.
- (12) Some D.C.'s pride themselves on how little time they spend with each patient so they, like the M.D.'s, can rush to the bank to make their deposits. There are two "doctors" in this area, so the rumor goes, who when they take in an associate he is to understand that "time is money" when he treats a patient and so stand outside the treatment room with stopwatches in hand timing how long the new doctor takes to treat a patient and he had better do it in less than three minutes or else! I hope medicine has similar kinds of creeps. □

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(Continued from page 4)

Dr. Homewood has not only an impressive position as a research scholar and writer but also as a clinician and educational administrator. As president and Dean of the Canadian Memorial Chiropractic College in Toronto in 1958-61 he inspired and was heavily responsible for conceiving the beautiful new quarters for the college.

He was a member of the faculty at Lincoln Chiropractic College from 1963 to 1965, serving as Chairman of the Department of Chiropractic and taught classes in Neurology and was supervisor of all publications. In 1967 he returned to Canadian Memorial College to raise \$500,000 for the new campus in connection with the Canadian Chiropractic Association. 1967-1969 he was President and Dean of C.M.C.C. and supervised planning and construction and furnishing of the new plant.

In 1970 Dr. Homewood returned to the Los Angeles College of Chiropractic and served on the faculty as instructor in Neurology and Chiropractic Principles, then as Dean and as President in 1976-77, following the retirement of Dr. George Haynes. At L.A.C.C. Dr. Homewood again proved himself to be a capable administrator before his resignation with the advent of a new Board of Regents. At the present time Dr. Homewood is back at Western States Chiropractic College, teaching Neurology and resting from his many strenuous years of labor in the interests of the chiropractic profession.

Dr. Homewood receives our tribute in this journal because of his deep appreciation of the breadth and depth of the potential contributions which chiropractic may yet demonstrate to the world as more doctors of chiropractic wake up to the vast opportunities which are opening to Chiropractic Family Physicians. He has had a clear vision that chiropractic is truly an alternate healing system in full and capable competition with any and all other systems of health care. □

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cles as the criterion. Neurologic evidence today indicates that the flat muscles are more sensitive and more specific for diagnostic purposes. Clinically this seems to be borne out.

With increasing knowledge the thrust of theoretical application changed. After recognizing the importance of tone it became necessary to explain why the tone changed. The vertebral subluxation, so important to the chiropractor, needed a better explanation than it being caused by crossing the legs or stepping off a high curb. It soon became apparent that abnormal tone and the muscle spasm displacing the vertebra were a reflection of a disturbance within the body. As the need and the processes involved for adapting to stress became recognized, it was then only a short step to realizing that the adoptive ability of the nervous system was paramount.

The brain centers were and still are largely impervious to our understanding and use. However we learned the vast network could be influenced even if we didn't know how to affect the command center. The vertebral thrust used by the

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REFERENCES:

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chiropractor somehow provided salutary influences that encouraged the nervous system to again take over bodily repair. Later experimentation showed that a slight stretch on certain tissues somehow initiated a vasomotor response as indicated by a change in tone.

The work of Sir James Mackenzie in Scotland established that the internal organs could express their malfunction by influencing the surface of the body. This work was later extended by the experimentation of Dr. Francis Marion Pottenger and more recently continued by Dr. Terrence J. Bennett. Although Sir James was published originally sixty years ago, it was largely neglected because it did not fit into the accepted ideas of that time. Even today there is resistance to accepting the frequent evidence of viscerosomatic reflexes.

It is due to the growing understanding of the affect of the internal organs on the surface of the body that the holistic principle will prosper. The vital organs were not so named capriciously. Environmental changes are reflected in the viscera which in turn affect circulation to the surface by way of the vasomotors, hence the importance of recognizing viscerosomatic reflexes.

If, as alluded to earlier, the nervous system is thrown out of balance by too much or too prolonged stress, we may expect a disturbed function to occur in the responding internal viscera and a corresponding circulatory malfunction in a surface reflex area. In both instances, only measuring tone will reveal the trouble in the beginning.

If the body is able to adapt, the nervous system will come back to homeostasis and normal function will again resume with the disappearance of symptoms. If the nervous imbalance is too great, the symptoms persist and the disease process goes on. With nothing in nature standing still, it becomes a question of whether the body can regain its equilibrium or the disease process continues to worsen with perhaps changing and more chronic symptoms.

Fortunately the body seems to never lose sight of its original blueprint and the desire for health is strong. Clinicians have found that they can influence the surface and thus have a salutary effect on the internal viscera thereby assisting the organism in regaining control of its functions, so that health may be restored. The use of Neurovascular Dynamics involves merely a light stretch and corresponding recognition of the normalizing of tone of the flat muscle being treated. This is predicated on the fact that every internal organ connects neurologically with one or more places on the surface. As the flat muscle returns to normal tone so also does the function of the reflexly connected internal organ and likewise the surface manifestations even though far removed, whether it be the cold sore or the sick heart. □

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Dr. Nelson's Statement To ACA August 11, 1976

Four years ago the House of Delegates created the Council on Diagnosis and Internal Disorders. In their wisdom they recognized that chiropractors properly diagnose and also are concerned with internal disorders. This council, then, comprised of general practicing physicians, is concerned that this profession be recognized as a primary health care provider. We have fears that ACA is not diligent in presenting a strong public image in this direction.

Unless the organization that speaks for the chiropractic profession maintains a strong posture that chiropractors are general physicians, there is little likelihood the various concerned governmental bodies will see chiropractic other than a limited technical specialty. After 80 years the general public still views chiropractors as "bad back" specialists. The ACA is, unfortunately, encouraging that view. This council shudders at the trend becoming only too obvious in ACA public relations.

At one time the ACA distributed pamphlets titled, "What to do about Colds," "Why Suffer with Asthma," "An Upset Stomach may be a Danger Signal," "Your Heart and Its Care," "What You Should Know about your Kidneys," and "Digestive Defects are Correctable." Today, not a single one of these titles is available. ACA does not now suggest in any of its public relations literature that chiropractic may be beneficial for colds, asthma, heart conditions, kidney condition or digestive defects. Instead, public relations emphasized back problems, posture and the ambiguous but recognized advantages of good health. This council is very concerned that chiropractic is being portrayed as a limited profession and consequently a possible ancillary but not an alternative to medicine.

The members of this council regularly diagnose and treat conditions of their patients as diverse as the discontinued pamphlet titles. For 80 years chiropractors have treated successfully a wide range of functional visceral problems. To deny this clinical truth is to destroy the continued growth of and public confidence in this profession. Certainly ACA would not deny that chiropractic has in the past, about 1895, helped hearing problems.

The ACA pamphlets that are now available strongly point to chiropractors as being essentially spinal specialists. This is contrary to the ACA policy as expressed in the Master Plan Definitions. The definitions point out the importance of the spinal column **and** the nervous system. They further refer to "the restoration and maintenance of health" which can only be physiologically accomplished by means of the nervous system. Spinal adjustment, then, is merely the technical procedure whereby chiropractors influence the nervous system; it is the nervous responses that effectuate the restoration and maintenance of health. The available pamphlets do not put the emphasis on the chiropractor's concern with the nervous system and thus by this important omission infer that neck and back problems encompass the field of this profession. However, if we are properly portrayed as being physicians concerned with establishing neurologic balance or homeostasis then our forte is as broad as the nervous system and all tissues so supplied.

On the other hand, if ACA truly intends to portray chiropractors as spinal specialists we then become in the same class as podiatrists, dentists and psychologists. If we accept this posture, we are definitely not primary providers and must accept the consequences and the weakening of our social position.

Our acceptance of an ancillary position in the healing arts will cause dismay among the general public who have learned that drugless therapy is most effective for their total health needs. This segment of the populace is growing each year partly as a result of competent and ethical practice by a good percent of this profession as well as an increasing skepticism with medical ethnics and propaganda. As an ancillary profession we are denying the public an alternative to the poisons and iatrogenic consequences of medicine.

Furthermore, unless ACA engages in a strong stance that chiropractors are total physicians, we are deserting the hundreds of students now matriculated in our CCE colleges. We have encouraged potential students with promotional statements to the effect that chiropractic is the second largest healing profession and that chiropractors are doctors. We show pictures of students looking at microscopes, using stethoscopes and generally associating chiropractors with procedures recognized as employed by physicians. In the colleges themselves the students are taught that they can influence the various viscera by their learned ability to affect the nervous system. However, upon graduation, they will now find their professional association does not believe what has been taught in the colleges. The colleges say chiropractic can help stomach problems, ACA shys away; the colleges teach chiropractic is effective in functional heart problems, ACA denies this; the colleges point out the T10-11 will affect kidney function, ACA doesn't want to suggest that chiropractic can do anything for the kidneys. This deliberate repudiation of the teachings of our colleges by ACA is repugnant to this council.

We are at a loss to understand why ACA should be ashamed or fearful of standing on the truth. Within the limited membership of just this council we have physicians who have very successfully treated and are now treating heart, respiratory and digestive problems, to mention but a few. If a chiropractor can successfully treat a condition, then chiropractic has the potential to be beneficial in that condition. Why not say so? We owe it to a confused and concerned public to tell them that chiropractic is an alternative to medicine in a great many cases. The trend today is toward a holistic attitude in healing. This conforms with our original premise and current chiropractic thinking. Yet, we hide our light under a bushel and let the innovation of our early great thinkers be usurped by an antagonistic and harmful philosophy.

The time is now. At the recent convention in Houston the various council presidents were eager to have their councils accept responsibility within ACA. This association has recognized the place of x-ray and orthopedics in the practice of chiropractic. This council, as a responsible arm of ACA, asks that ACA equally recognize that chiropractic internists are total physicians offering complete health services within the scope of their licenses to a public anxious to avoid the serious iatrogenic consequences of an alternative philosophy. We offer ACA the opportunity to visibly assure the citizenry, many of whom had a direct influence in the legal acceptance of chiropractic, that this profession will not betray the trust imposed on it.

The members of this council are practicing as primary providers, our colleagues are pleased, and consider themselves qualified, to use the appellation "doctor," the CCE colleges are aggressively pursuing a policy of improved standards befitting the awarding of a doctorate and the public, our benefactors, expect us to use our peculiar therapy to safely restore them to health. The spokesman for the chiropractic profession, ACA, must in turn educate the public in the large inclusive role that is within the capability of chiropractic. That we have tremendous capability for the public good is attested by 80 years of remarkable clinical achievements. We have a serious responsibility to the public trust to inform the people that an alternative to poisoning and mutilating therapy is available. We need a positive public relations program broadening the public's knowledge. The present restrictive, negative, tongue-in-cheek approach will eventually even destroy the will of our own people. This council emphatically urges ACA to wake up to the great potential inherent in chiropractic and accept its responsibility to the public by educating them to the health opportunities available to them. □

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stress. Psyche and soma cannot, and should not, be separated, as they are interdependent and interrelated. Just try to concentrate on some mentally taxing problem while sitting on the point of a thumb tack, or with a little pebble under one ischial tuberosity. Either of these objects would be stimulating a very limited area and number of receptor nerve endings, yet the demand for attention and corrective action is likely to overshadow the effort to concentrate. The bombardment of the nervous system by noxious impulses from subluxations, even below the level of conscious pain, is making demands that alter the psychological ability to cope optimally with other forms of stress.

These are many instances when the cause is not obvious, but, rather, a summation of mechanical, chemical, and psychological stresses that have produced the hypertonicity and dysfunction of the vertebral column as a functional organ. Superimposed upon the hereditary and acquired structural weaknesses or abnormalities subluxations and like-acquired structural weaknesses or abnormalities subluxations are likely to result. Specificity of cause may elude the most conscientious investigator, but the objective signs and symptoms of structural distortion and/or dysfunction are available for assessment by the knowledgeable. It would be a disservice indeed to fail to restore structural normality, because the cause cannot be ascertained, and force the patient to seek relief from Valium or other drug that helps cope with, or ignore, the psychologic stressors. Those irritations from abnormally functioning structure, although below the level of conscious awareness, may be facilitating pathways or summing in such a manner as to result in less than optimum response to psychological stress.

Iatrogenic risk in chiropractic practice does not appear to be as much from excessive "adjusting," but rather conscientious, well-intentioned "maladjusting." Thus, when abhorring the iatrogenic risk of allopathic medicine, it would be well to be certain that chiropractic, as it is being applied, is not placing patients at risk from "maladjusting," albeit of a lesser degree of danger.

It would seem that quality, rather than quantity, is the basis of justified concern.

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Name _____ Age _____

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This application is subject to approval by the Credentials Committee, and it is understood I shall be informed of acceptance. I am a member of ACA.

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My application fee of \$20.00 and first year's dues of \$25.00 are enclosed. **APPLICATION FEE IS NOT REFUNDABLE.** Dues will be refunded if application is not accepted.

Applicant's

Signature _____ Date _____

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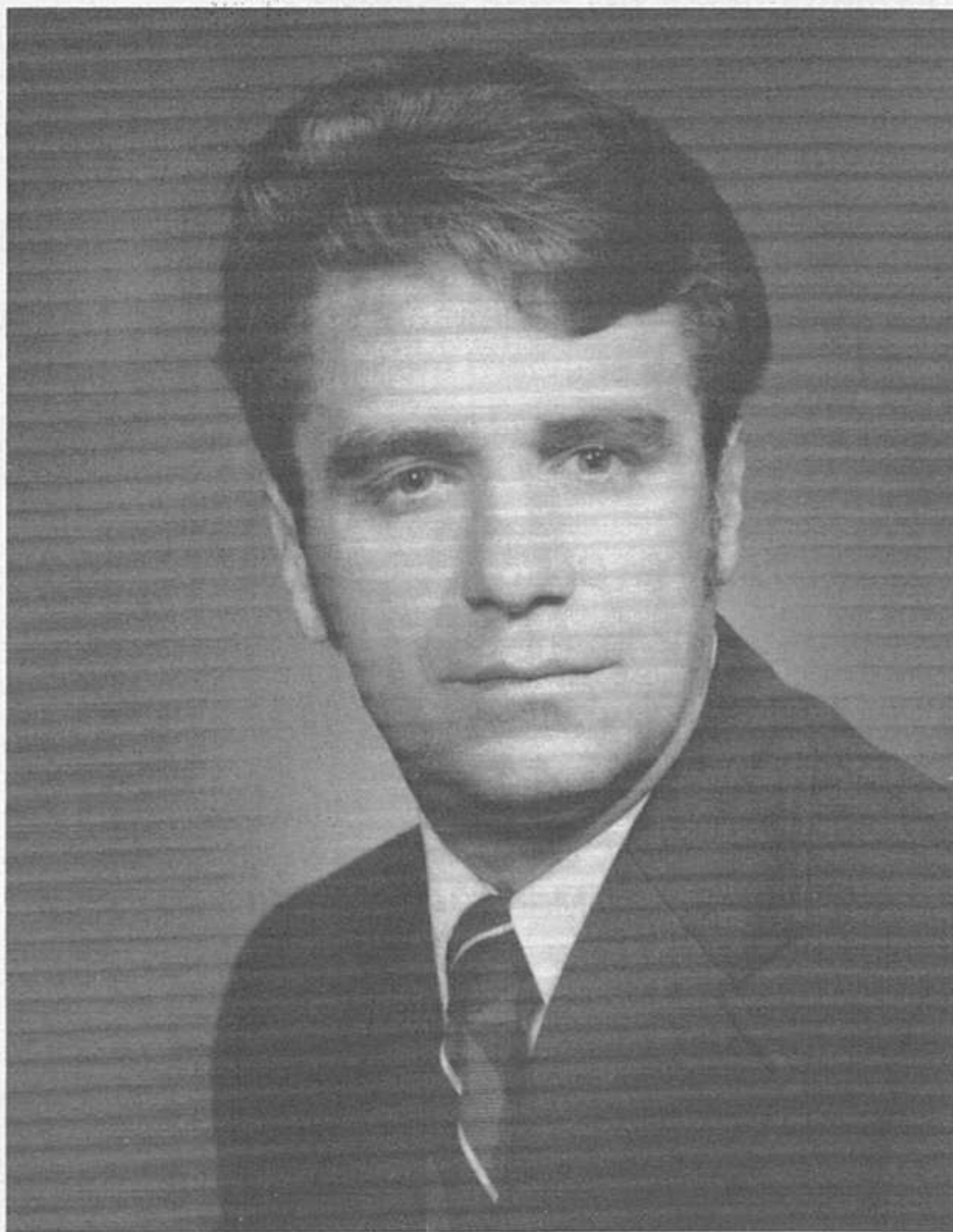
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OF THE AMERICAN CHIROPRACTIC ASSOCIATION

THE CHIROPRACTIC FAMILY PHYSICIAN

JANUARY, 1981

VOL. 3 NO. 2



MICHAEL F. BILLIG, D.C.

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By

Ralph J. Martin, D.C.

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the Chiropractic FAMILY PHYSICIAN

JANUARY, 1981

VOL. 3 NO. 2

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TRIBUTE TO DR. ELDRED A. WILSON

Late President of the Council on Diagnosis & Internal Disorders

Eldred A. Wilson, president of the Council on Diagnosis and Internal Disorders, died suddenly October 21, 1980. He had completed a successful first year in office and was just beginning his last year. An experienced chiropractic physician in a small Missouri town, he was the town 'doc.' The residents of Slater looked to and loved EA for his willing competence and dedication.

Looking forward to a well-earned vacation with Mrs. Wilson in Denver in June during the American Chiropractic Association annual meeting and presiding at the simultaneous meeting of the Council on Diagnosis and Internal Disorders, he had gotten as far as the Kansas City airport. There he was being paged because of an emergency in Slater. Driving back 120 miles he found an elderly patient critically ill with congestive heart failure. Being the only doctor available and the patient refusing to chance the hospital 20 miles away, EA rolled up his sleeves and went to work. Galvanism stopped the fibrillation. Manipulation slowed the tachycardia. Twenty-four hours of continuous care brought the patient from critical to guarded condition. Continued care produced recovery. EA never got his vacation.

EA was dedicated to improving the level of competency in his profession. He realized his had been an exceptional background in clinical training and he was anxious to pass his knowledge on to his colleagues. The Council on Diagnosis and Internal Disorders provided the perfect medium. He worked diligently to promote the council and finally became its president in June, 1979. During his term the council experienced its greatest membership growth.

His efforts, while appreciated by his council members, did not go unnoticed by the profession. In September of this year he was accepted as a Fellow in the International College of Chiropractic, Inc. This honor is reserved for that small percentage of people who have contributed the most to the chiropractic profession.

The chiropractic profession has lost a great physician. The town of Slater has lost their beloved doctor. The Slater Kiwanis Club has lost a loyal secretary with over two decades of service. While so many feel the immediate loss, we can all be thankful that such a good man lived and contributed so much. ☐

William A. Nelson, D.C.

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Some doctors move and forget to send us their new address so they stop getting their Chiropractic Family Physician which is still going to their old address. When you move be sure to send us both your **old** and **new** address. Our mailing card files are listed by ZIP CODE — without your old ZIP number we cannot find your card.

Editorial

"WHEN THEY PAGE US AT THE HOSPITAL . . . WILL WE BE ABLE TO ANSWER?"

by Richard H. Tyler, D.C.

It has been rumored lately that we, as a profession, will within the next two or three years, be on the staffs of most hospitals. To the majority, this might seem like a great idea. Indeed, on face value, it certainly is an idea of great promise. I might be the only one, however, who thinks of chiropractors on hospital staffs as being a potential disaster.

I understand that it was tried a number of years ago at one of the larger local hospitals with frightening results. Our resident chiropractic fanatics wound up running up and down the halls blasting the surgical and medicinal therapy, and spouting off about good old "innate". A measure of their distress may certainly have been justified, for we are all aware of the gross ineptitude of many medical procedures and the madness of knife-happy surgeons. However, when your foot is in the door of someone else's home, you wiggle your toes and test the climate. You don't take that foot and start kicking the person who lives there. Anyway, our "chiropractic crusaders" were soon asked to leave. This proved to many that we were incapable of working with others in the health disciplines. What had been a golden opportunity to introduce and instruct others in conservative measures was lost because of a few self-righteous zealots.

The opportunity to become involved in hospital procedures is about to come around once again. This time, undoubtedly as a legal mandate. True, the modern Doctor of Chiropractic might be more sophisticated than his counterpart of a few years ago, but there are still too many of the strange among us. What is just as important, is that those who might engage in a hospital practice might be totally unqualified to diagnose anything more than a cut finger, and would end up with little or no autonomy and be nothing more than a prescription item for the M.D.

It is hoped that before anyone is allowed to enter hospital practice, they would be properly trained in advance. It is inconceivable to me to think that anyone should have hospital privileges without being familiar with a broad scope of diagnostic procedures. This can best be obtained through the graduate program in Diagnosis and Internal Disorders.

Let's not blow it, chiropractic. We will soon be in hospitals. Let's act like physicians. No — not medical physicians, but chiropractic ones. We will be in a position to teach our more radical brethren about the value of conservative health measures through professional example.

Improperly trained or fanatical, we could have that foot that's in the door chopped off before we can get it as far as the gastrocnemius. Properly trained we will soon have a unique opportunity to show all the healing arts professions just how good we are. ☐

TRIBUTE MICHAEL F. BILLIG, D.C.

Few positions are more important to our profession than those held by members of the fifty state boards around the country. State board members are the literal guardians of our rights and protectors of our future. Each member stands as that bridge between their respective legislatures and the profession. Because of the sensitivity of the office, it's extremely important that only those dedicated to a full practice as chiropractic physicians, hold these positions of trust. Few doctors in our profession have proven more worthy of that trust than Dr. Michael F. Billig of Vermont.

The state of Vermont has an extremely viable chiropractic law. A complete range of diagnostic procedures may be used, including penetration of the integument with therapeutic procedures commensurate with the diagnostic findings. For the relatively short period that I practiced in Vermont, I got to know Dr. Billig fairly well. I was continually being impressed by his dedication to the profession. Whenever it came time for the board examinations, he would take considerable time off from his practice to be sure that those who took the examination were qualified to practice, not only from their demonstrated didactic and clinical expertise, but from their philosophical dedication to eclecticism.

After graduating from Lincoln College of Chiropractic in 1962, Dr. Billig toured New England with a friend and fell in love with the beauty of Vermont. He started practice in 1965 and has since been the president of the Vermont Chiropractic Association for four years. This was followed by four years as the president of the Chiropractic Board of Examiners for the State of Vermont, a position he currently holds. He is also presently the state delegate to the American Chiropractic Association.

I'm sure that Dr. Billig would be the first to recognize the fact that he is but one of many dedicated chiropractic physicians in Vermont who have given so much of their time to guide and protect their profession. He is, however, an example for others to follow and a physician of integrity, unyielding in his resolve to perpetuate only the highest standards of health care for his state and for his country. ☐

Richard H. Tyler, D.C.

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NEW IMPORTANCE OF ERYTHROCYTE SEDIMENTATION TESTS (ESR)

Ralph J. Martin, D.C.

This test, while not much preferred among medically-trained technicians and physicians, has certain basic values which no other test has ever achieved. It has been around for a long time and may have more services to perform in future diagnosis than it has in the past. Medicine is reluctant to place any credence on the differentiation between the diseases of abnormal physiology and those of actual pathology. We firmly believe that it is a fundamental distinction of which, it may be said, "Its time has come." More and more the health services are being forced to place greater emphasis upon prevention of illness and catastrophic diseases. As prevention is being more seriously researched there can be no escape from the simple fact that the more successfully normal function can be maintained within the person, body, mind and emotions, the better the prospects for prevention of pathology, degenerative disease processes and improved resistance to infections.

This is what the sedimentation rate or index test is all about — to determine whether the physiological processes are normal or degenerative processes are active — and to a considerable extent, how active.

Goodall's Clinical Interpretation of Laboratory Tests, fourth edition states "The sedimentation rate or index is the fall of the red cell column in one hour measured in millimeters. It is a non-specific test which is accelerated in a variety of diseases and in pregnancy. Sedimentation rate remains within normal range in functional nervous disease, benign tumors such as uncomplicated fibroids and cysts, asthma, hay fever, essential hypertension, diabetes melitus, cirrhosis of the liver, simple peptic ulcers, hydronephrosis, early acute appendicitis, head colds and hypertropic arthritis.

TABLE 7 CHANGES IN SEDIMENTATION RATE
Increased

Physiological: Pregnancy after second month menstruation. Infection processes: Acute general and localized infection. Chronic active infections Tuberculosis Syphilis Rheumatoid carditis Blood Dyscrasia: Leukemia Anemia Malaria during paroxysms Erythemia	Poisoning: Lead Arsenic Alcohol Miscellaneous: Coronary thrombosis Hemorrhage Advanced Malignancy Hyperthyroidism Nephritis and nephrosis Certain cases of severe liver disease Decreased Sickle cell anemia Certain cases of severe liver disease.
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ERYTHROCYTE SEDIMENTATION RATE (ESR)

From
"Interpretation of Diagnostic Tests"
Jacques Wallace, M.D.

ESR is useful to:

- Detect occult disease (e.g., screening program)
- Follow course of a certain disease (e.g., tuberculosis, rheumatic fever, myocardial infarction)
- Confirm a diagnosis or a differential diagnosis (e.g., acute myocardial infarction versus angina pectoris; early acute appendicitis versus ruptured tubal pregnancy or acute pelvic inflammatory disease; rheumatoid arthritis versus osteo-arthritis)

Changes in ESR

Disease	Increased in	Not increased in
Infections	Tuberculosis (esp.)	Typhoid fever
Cardiac	Acute myocardial infarction	Undulant fever
	Acute rheumatic fever	Malarial paroxysm
	Post commissurotomy syndrome	Infectious mononucleosis
		Uncomplicated viral disease
Abdominal	Acute pelvic inflammatory disease	Angina pectoris
	Ruptured ectopic pregnancy	Active renal failure
	Pregnancy - third month to about 3 weeks post-partum	Heart failure
	Menstruation	Acute appendicitis (first 24 hours)
		Unruptured ectopic pregnancy
Joint	Rheumatoid arthritis	Early pregnancy
	Pyogenic arthritis	Degenerative arthritis
Miscellaneous	Significant tissue necrosis (especially neoplasms)	Peptic ulcer
	Most frequently malignant lymphoma, cancer of colon and breast)	Acute allergy
		Polycythemia vera
		Secondary polycythemia
	Increased serum globulins (e.g., myeloma, cryoglobulinemia, macroglobulinuria)	Sickle cell anemia
	Decreased serum albumin	

Decreased	Increased in	Not increased in
	Hyperthyroidism	
	Acute hemorrhage	
	Nephrosis, renal disease with azotemia	
	Arsenic and lead intoxication	
	Dextran and polyvinyl compounds in blood	

Extreme elevation of ESR is found particularly in association with malignancy (most frequently malignant lymphoma, carcinoma of colon and breast) hematologic disease (most frequently myeloma), collagen diseases (rheumatoid arthritis, SLE, etc.) renal diseases (especially with azotemia), infections, and others (e.g., cirrhosis).

TABER'S MEDICAL DICTIONARY (12th Edition)

Sedimentation rate: "Laboratory test of speed at which erythrocytes settle when an anticoagulant is added to blood. In this test, blood to which an anticoagulant has been added is placed in a long narrow tube, and the speed at which the red cells settle is observed."

From years of clinical experience we are forced to conclude that the minimal utilization of the ESR tests is due to disinterest of the medical practitioners in differentiating between diseases of abnormal function and pathologic diseases.

Since we are particularly concerned to make this distinction as early in the diagnosis as possible, we are therefore placing considerable emphasis upon the value of the ESR test. By closely scrutinizing "Interpretation of Diagnostic Tests" by Wallace, it is clearly obvious that the conditions in which there is no increase in sedimentation rate, tend to be diseases more of functional disorders than true pathologies. This gives further validity to the extensive use of the ESR test to differentiate between abnormal function disorders and serious pathological disease manifestations. ☐

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Book Reviews

THE NEW ERA CHIROPRACTOR

by
R.M. Failor, D.C., N.D.

I must admit to the fact that I had never heard of the author until this publication was sent to me. I must further state that I found it interesting and of value to my practice. In soft cover it fills 88 pages including the index.

Dr. Failor didn't enter chiropractic college until he was 41 with a wife and children. This relatively late start apparently worked in some measure to his benefit. He approached his new profession with a mature appreciation of the skills required to be a physician. Early in his career, he had the opportunity to experience a hospital situation which inculcated in him the desire to be as eclectic in natural therapeutics as the scope of his license would permit.

The book is primarily concerned with the nutritional and manipulative aspects of chiropractic practice, demonstrating rather cogently how extensive conservative treatment of this nature can be. Its six chapters cover:

- (1) The Vertebral Column
- (2) Soft Tissue Manipulation
- (3) Gynecology
- (4) Standard Orthopedic Tests
- (5) Treatment and Care of the Body
- (6) Nutrition

Of particular interest is the coverage of the soft tissue work. This is an area that we often neglect, concentrating rather on specific adjustive procedures instead. This is unfortunate, for soft tissue work specifically applied can be of considerable value. I also appreciated the section on gynecology. Again this is an area of professional timidity which leaves many a female patient with only radical procedures as an alternative.

While I like the broad use of modalities in addition to specific adjustive procedures, this book serves a valuable service by expanding our exposure and knowledge of the manual and nutritional aspects of our practice.

The book may be obtained by contacting R.M. Failor, D.C., N.D., P.O. Box 2021, Palm Desert, California 92260, or obtained from most chiropractic college bookstores. ☐

Earl Mindell's VITAMIN BIBLE

Rawson Wade Publishers, Inc., New York
\$6.95 available at most major book stores.

This is a handy reference book on vitamins and nutrition and attempts to provide guidance to explain the confusing, often dangerous, interrelation of drugs and vitamins. The author is a practicing pharmacist who is committed to "natural" vitamins and "natural unprocessed foods."

He is concerned with providing the general public with the information that is needed for the individual to secure "complete" nutrition without pursuing fads and cults.

Here are a few statements taken from the back cover:

- * How vitamin needs vary for each of us, and how to determine yours.
- * What drugs and pollutants deplete your body of necessary vitamins.
- * What special food cravings can mean about your vitamin needs.
- * How to substitute natural substances for tranquilizers, sleeping pills and other drugs.
- * How the right vitamins can help your heart.
- * Exactly how to spot vitamin and nutrient deficiencies.
- * How vitamins can retard aging.
- * How vitamins can fight depression.
- * Vitamin cautions everyone should know.

The author recognizes that as people learn more about common sense care of their own bodies, based on reliable information, the first great step in preventive medicine is accomplished. As normal functions are maintained, the likelihood of serious illness and the catastrophic costs of hospitals are prevented. Mindell recognizes that people must learn to rely more on their own informed common sense and less on sophisticated medical science in order to bring down the staggering costs of health services. This book is recommended for family physicians to recommend to their patients, and for physicians themselves so you will know what your patients are being told. ☐

Clinical Roundtable CLINIC NOTEBOOK

by
Richard H. Tyler, D.C.

... being a potpourri of diversified conservative therapeutic approaches for specific pathologies.

We so often fail to utilize the gifts of conservative health care because of the almost innate chiropractic indoctrination that we are spinal technicians and nothing more. This is a disservice not only to the well-educated chiropractic physician, but to his patients who might be denied all the dimensions of conservative therapeutics.

With this in mind, what follows is one of the more common areas of patient health concerns that we may treat diversely for more satisfactory results.

Earache: An otoscopic examination should be given to determine severity and complications.

Homeopathic remedies: Belladonna
or
Pulsatilla
or

Arsenicum
or
Hepar Sulph

Soothing applications: Olive or castor oil mixed in equal parts with hot milk placed by dropper into inflamed ear.

Four or five drops of oil of roses in equal portions with vinegar every two hours. After this, drink a quarter of a glass of water from a glass that includes two drops of apple cider vinegar.

Physical therapy: Using positive galvanic current, place active pad in back of affected ear with the inactive pad on opposite side of neck.

Chiropractic adjustment: Particular attention should be paid to atlantoaxial complex for subluxation.

The preceding is by no means comprehensive, but it is hoped that it might be sufficient to encourage some of you reading this to conceptualize your chiropractic practice in broader terms. From time to time we'll expose you to other ideas you might find viable alternatives to excessive therapeutic restriction. ☐

(Clinical Roundtable, cont'd)

EFFECT OF ALTITUDE ON HUMAN HEALTH

This is a clinical report on cases observed in an area where altitude varies from sea level to mountain resorts, where large numbers of people either live the year around or for brief vacation periods at altitudes of 5,000 to 6,000 feet or more.

Case No. 1: A 76-year-old white female for whom I had provided health care periodically for about eight years developed a cardiovascular condition which defied specific diagnosis and stubbornly failed to respond to any form of conservative treatment. The altitude of the high desert community where she lived was about 3,000 feet above sea level. In order to secure more sophisticated diagnostic resources, a cardiologist in a major hospital in San Bernardino was called and arrangements made to have the patient admitted immediately as her condition required emergency consideration. I called the hospital the next day and spoke to the patient. To my amazement she sounded perfectly well, and was having a grand time providing cheer and companionship to the patients in her ward. She had had only a cursory examination and had been given no medication. Since she was feeling so well, she was released in a couple of days and returned home to her home in the high desert. As soon as she had been home a few hours her condition began to return and she called me. By this time, I was convinced that her system did not tolerate the high desert altitude, and I suggested that she leave for awhile and stay with her son in Santa Barbara. This she did and had no trouble there and she stayed several months. When she returned to her home she could only stay a few days before the cardiac problem returned and she had to return to her son, whereupon she sold her place and continues to live nearer sea level.

Case No. 2: A 59-year-old female spent a month in a mountain resort at an altitude of about 6,000 feet. About the second or third day of the fourth week she took a walk with her dog and while still about two blocks from her house she felt a weakness come over her which frightened her. Instead of sitting down to rest, she forced herself to struggle to get home in spite of increasing weakness and really just made it

before she collapsed. Her husband found her in this condition and took her to their home in the high desert which was an altitude of 3,100 feet above sea level. He went back to the house in the mountains and got their things which had been left, and terminated the mountain residence in order to be with his wife.

She continued to experience weakness and shortness of breath until he took her to Pasadena and there she felt no problem with weakness or breath. He left her there for two weeks and she was apparently normal. With this test period concluded, they decided to move back to Pasadena where they have been for five years now and she has enjoyed normal health for her age. However, for the first year or two she experienced a return of the weakness and difficulty in breathing whenever they went back to the high desert and found it expedient to return back to the lower altitude the same day before her condition became critical.

Case No. 3: A 45-year-old Navy officer retired after 26 years of service and purchased a house in a high desert area which was about 3,000 or more altitude above sea level. In the fall of the third year, he went deer hunting in the mountains for a week or more. The day after he returned to his home, he died suddenly of a heart attack at the age of 48. It appears that his body was conditioned to living at sea level, and the higher altitude placed a stress upon his cardiovascular system which exceeded his adaptive capacity.

Realtors in mountain resort communities can be brought to reluctantly admit that it is not uncommon for middle age and older people to become enamored of the delightful mountain situation, buy lots and build expensive homes which they move into. Only after they have lived there for awhile, do they learn that the high altitude brings on cardio-respiratory problems which forces them to sell and return to live at a lower altitude. Before investing large sums in such ventures, one would do well to rent in such a resort area and live there for a season before making a decision for a permanent move. ☐

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LETTERS TO THE EDITOR

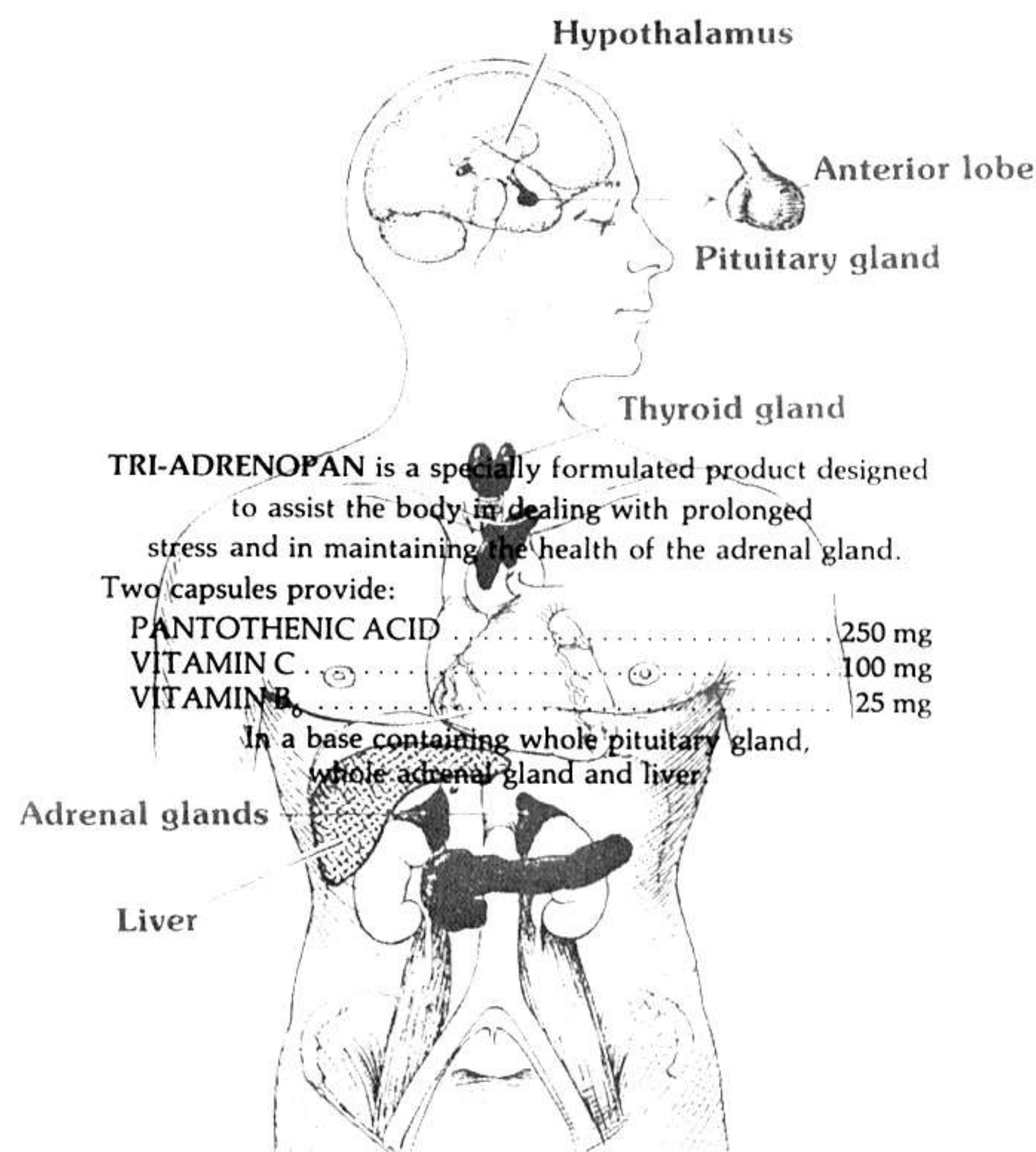
Dear Dr. Tyler:

Just a note to thank you for your excellent publication "The Chiropractic Family Physician." I read it from cover to cover. You boys are doing a super job of 'putting it together.' I think you are not only very erudite but I like the gutsy way you edit your articles — written so sensibly — critical at times but done in good taste. And again, am most grateful for your sending such an excellent publication.

Most gratefully,
Dr. C.B. Whitten
322 W. Schwartz St.
Salem, Ill.

(Continued on page 15)

TRI-ADRENOPAN



ANABOLIC LABORATORIES, INC.
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(Continued from page 13)

Dear Dr. Nelson:

The "Chiropractic Family Physician" is one of the finest pieces of Chiropractic literature in years. Keep up the good work.

Respectfully Yours,
Arthur P. Ferrara, C.C.
1523 11th Ave.
Brooklyn, N.Y.

To the Editor:

We want to tell you that we feel the last issue of The Chiropractic Family Physician was the best ever. Especially the article Dr. Nelson wrote about the future of Chiropractic, and how we should as individual physicians and our National Associations should inform the public about the broad scope of Chiropractic therapeutics and the alternative health care system, we can provide the public.

Yours,
Richard L. Cohen, D.C.

Dear Editor:

Three cheers and a grand Hurrah for your editorial and for the article on Chiropractic's weaknesses by Dr. Godwin. I couldn't agree more with the sentiments expressed in those two articles. They should be made required reading — and memorization — as a condition for graduation from chiropractic college!

My personal pet peeve is the proliferation of "techniques" by various hustling promoters who make some rather outrageous claims with absolutely no objective verification or connection to the real world of human physiology. As for the doctors who buy their nonsense I can only say P.T. Barnum was right — there is one born every minute!

Sincerely,
L.G. Morgan, D.C.

Dr. Arthur W. Breakiron, 66, Fresno Chiropractor

Services for Dr. Arthur W. Breakiron, 66, will be held at 10 a.m. Wednesday in Colonial Funeral Home. Burial will be in Belmont Memorial Park.

Dr. Breakiron died Saturday.

He was a past member of the Northern California Professional Standards Committee of the California Chiropractic Association and was named Distinguished Doctor of 1962 by the Fresno chapter of the organization. He was a past president of the California Chiropractic Association. He also was a past president of the board of directors for the Fresno Boys Club and was a 25-year resident of Fresno.

He is survived by his wife, Lois; a son, Elden of Terra Bella; a daughter, Vera Bogosian of San Ramon; two grandchildren; and two great-grandchildren.

The family requests that any remembrance be sent to the Optimist Boys Club of Fresno.



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THE LOST ART — INCLINE PLANE TECHNIQUE

A.E. Homewood, D.C.
Western States Chiropractic College

Two powerful forms of chiropractic technique were taught in the University of Natural Healing Arts, Denver, Colo., by Dr. Homer G. Beatty, when this writer enrolled as a student more than 40 years ago. It was with considerable surprise the discovery was made that not all chiropractors knew or used Incline Plane or Traction Swing Techniques in their practices. In fact, few had a knowledge of basic distortion-compensation, motor reaction, muscle keys, muscle releasing, soft tissue (abdominal) techniques, or those techniques so useful for eye, ear, nose and throat conditions. As students, we did not appreciate that "wholistic" chiropractic was being taught, as distinguished from the "segmental" approach of the majority of colleges. We did not realize that the adjusting of articulations of the foot, the temporomandibular joint, or the "suggestive adjusting" of the sutures of the skull were not part of the armamentarium of every chiropractic physician.

Incline Plane Technique may be of import and interest to the members of C.C.D.I.D., since there is likely to be more tendency to care for the broad spectrum of human disorders. A brief description of the Incline Plane table would appear to be the first order so that some visualization of the corrective techniques may be possible.

The Incline Plane is a narrow table, approximately 7 feet long and 18 to 20 inches wide, hinged at its centre to a saw-horse, much like a teeter totter. The legs at the head end are hinged and braced together to move as a unit, allowing the head of the table to be depressed a variable degree, including contact with the floor. The legs at the foot of the table may be fixed or hinged. Two notched boards, affixed to the headward legs of the saw-horse, receive the headward table legs and regulate the degree of inclination. The entire table is approximately 28 to 32 inches high, depending upon the stature and convenience of the doctor. The other requirements are ankle straps to secure the patient to prevent sliding down the table onto the floor, and a 7 inch roll to be placed under the knees. A folded sheet or blanket on the top of the table and a pillow for the head complete the requirements. No padding or upholstering is desirable. The more slippery the table top, the better.

There have been many modifications, refinements and elaborations made to the simple table, but the basic principle of reversing the gravitational effect upon the structures and tissues has been retained.

All would agree that gravity is an ubiquitous stressor for all living matter, with particular detrimental effects upon man, the biped. The history of individual man is a circle from birth, unable to raise the head against the pull of gravity, through the stages of holding up the head, sitting up, crawling, standing, walking, running; a few years of almost constant activity to consternation of adults; the dignity of employment with reduced play time; gradual, but continuing reduction of physical activity until retirement; then the rocking chair, slippers and pipe; perhaps a period of confinement to bed; finally death. The circle completed.

It is well known by physicians that the stress of gravity with the advancing years tends to cause deterioration of posture and thinning of intervertebral discs, as well as many other structural changes. The reduction of height is another obvious effect of the stress of gravity with the advancing years.

Dr. Robert Martin of Pasadena, Calif., has produced in recent years, a sophisticated, anti-gravity unit that is "powerful medicine" for a vast array of vertebral problems, but lacking some of the advantages of the Incline Plane for many other conditions. This Gravity Guidance Unit permits the patient to be completely inverted, exercise in such a reversed gravitational field, or have powerful extension technique applied with gravity's complete cooperation.

While the Incline Plane does not boast the powerful extension and anti-gravity possibilities of Dr. Martin's Gravity Guidance Unit, it does have advantages and a broader scope of use. The price of construction is minimal, but appearance adds little to the decor of the office. Dr. Martin's unit is in the thousand dollar range, requires more space, but is impressive and looks like a therapeutic instrument. The Incline Plane can double as an examination table or a physiotherapy plinth. In fact, the general anti-gravity treatment can be combined with many of the physiotherapy applications to reduce the time element. Some physicians have one of these tables in each P.T. booth to permit the C.A. to administer the anti-gravity treatment at the same time as the P.T. modality is being given. The doctor is then free to move from booth to booth for the specialized techniques that only he can apply.

The patient is placed supine on the table with the seven inch roll under the knees. The ankle straps are adjusted in length to assure that the patient is situated on the table with a slight excess of weight headward of the fulcrum to assure that, when the headward legs of the table are pushed toward the centre, the table will tilt and remain angulated until the end is raised manually and the legs locked in position. As the legs are pushed footward, they lock into the notched board on the floor to provide the degree of angulation desired.

Another disadvantage should be obvious. The weight must be supported manually as the table is tilted and again to bring it back to the horizontal position. Of course, the expenditure of additional money has produced units that do all these tasks by an electrical motor at the touch of a foot switch and is a mechanism of which to be proud.

With the patient now inclined with upper torso lowered to the degree desired, the operator reaches under the gluteal muscles of each side and gives a footward antero-lateral tug to help flatten the lumbar curve, then from the head of the table slides the hands, palms up, under the scapulae and raises the patient's upper trunk slightly and pulls headward. Patient, sheet and pillow should slide headward on the table until the ankle straps completely limit any further movement.

The doctor will be pleasantly surprised at the ease with which cervical adjustments may be made after the patient has been in the incline position for a few minutes. There seems to be an inability to hold against the adjusting, thus care must be exercised to avoid an excess of force, and, of course, the doctor must adapt his

position and direction of thrust to this unusual patient position. This writer usually used the Incline Plane after adjusting most of the vertebral column, then adjusted the cervicals and applied a Dorsal Longitudinal extension thrust in keeping with Dr. Beatty's admonition, "Always complete your adjusting with a Dorsal Longitudinal to undo the damage done with the adjusting!" The extension force of the Dorsal Longitudinal may be focused at any vertebral level down to and including the lumbosacral articulation.

The Lymphatic Pump for intrathoracic conditions should prove more effective when applied with the aid of anti-gravity, as are vibration of the paranasal sinuses, cranial techniques and those for the cervical lymphatics and thyroid. Abdominal techniques for emptying the stomach, draining the gall bladder, decongesting the liver, stretching abdominal adhesions, raising the transverse colon, and moving the bolus along the intestinal tract are aided by the anti-gravity position. Venous and lymphatic return from lower extremities, pelvic and abdominal cavities is encouraged by this position. Techniques for the drainage of varicosities are even more effective with the aid of gravity.

The Incline Plane may be used for adjusting much of the vertebral column, but requires considerable adaptation on the part of the physician to the unusual position and decreased force required. The patient lies prone over a seven inch roll over the pelvis and with another roll under the ankles. Again, the length of the ankle straps must be regulated to allow an excess of weight of the patient to be headward of the fulcrum. Considerable awkwardness will be experienced in attempting to adjust the thoracics above the apex of the kyphosis in a footward direction, but the T-M style of technique can be easily modified and is found effective for nearly all vertebrae of the upper thoracic and lower cervical areas. It will be a pleasant experience to find how easily these structures move with the aid of gravity. Lower thoracics, lumbar and sacroiliac articulations move with much less P-A force than when the same type of technique is used on a conventional table.

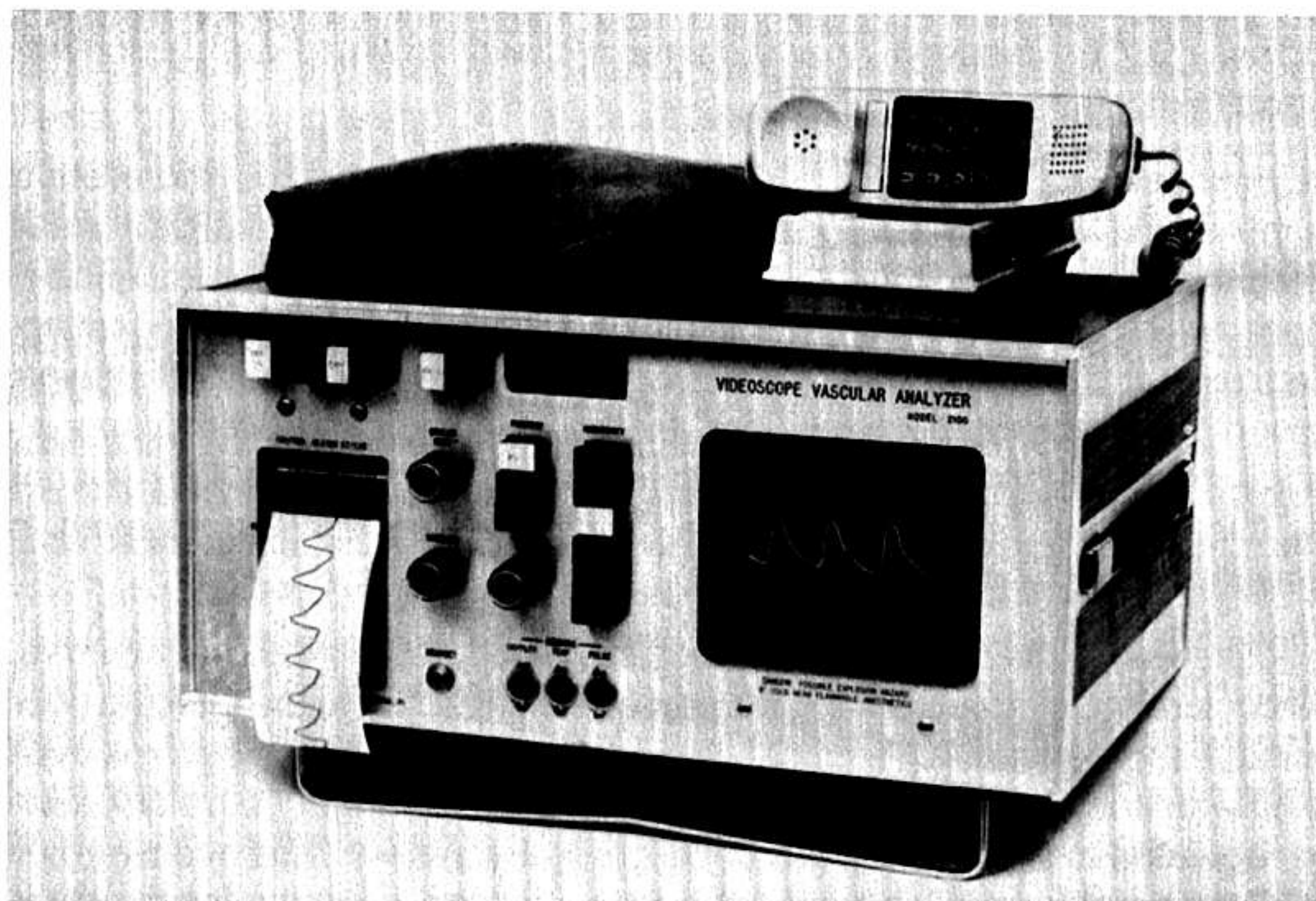
Various exercises may be beneficially employed by the patient while in the incline position. Curl-ups and deep breathing would be done in the supine position and back arching in the prone position, as examples.

It is hoped that this brief re-introduction to such an old, but potent technique of structural correction may spark interest in the younger group that this valuable adjunct to chiropractic may be resurrected, refined, and re-established in its rightful role within the professional armamentarium. ☐

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CHIROPRACTIC AND NEURO-VASCULAR CONDITIONS

by
W.J. Kelly, D.C., F.A.C.C.S.

Explosively rapid developments in sophisticated technology as well as physician awareness have resulted in the rapid proliferation of vascular diagnostic studies throughout the professions during the last six years. Prior to that only a few research-oriented academic facilities existed, and their major thrusts were instrument development and physiologic investigation. We are currently in an era of much broader application of these techniques, which are finding a proper place in the chiropractic physician's office. Simultaneously, the family physician, internist, neurologist, and cardiologist have joined the vascular surgeon in appreciating the value of noninvasive quantitative and qualitative studies of the very common conditions of the intracranial, extracranial, and peripheral vascular systems.

This article is intended to serve the clinician as an introduction regarding methodology, instrumentation, and available data in noninvasive vascular diagnostic studies. The study of the patient with a vascular condition begins in the physician's office, and the techniques described permit an effective distinction between many pathologic conditions and those of neurological in origin with modest requirements in equipment and expertise. Many tests can be performed by a nurse or technician and are both reliable and simple to interpret in the office setting.

Your instrumentation should include capabilities that will enable the following vascular examinations: Blood pressure ratios, Segmental plethysmography investigation of the digits in both upper and lower extremities, Arterial and venous ultrasonography by Doppler of the major vessels of both the arterial and venous trees, and Temperature gradient studies of the dermatone and myotone patterns.

PLETHYSMOGRAPHY: Plethysmography is a technique for recording, and objectifying, blood volume changes of a tissue, and is suitable for studying the circulation of a part. Plethysmographs usually consist of three components: a pick-up unit which makes contact with the part to be studied and which transmits any volume changes of the part which occur, a transducer which converts the volume change to electric energy, and a recorder which makes a permanent analogue of the action.

Plethysmographs have been used commonly for years as research instruments for studying the circulation. One of the early plethysmographs was that designed by Johann Swammerdam in 1732.

The digit has been an area of intensive study because the finger tip or toe represents a readily available, highly vascular area. Thus, volume changes in these structures represent changes in circulation through the skin and subcutaneous tissues. The digits represent the terminal portions of the circulation in which disease often begins. For example, it is more common to have ulcers of the skin of the toes with gangrene than to have ulceration or gangrene of the calf muscle.

STUDY OF THE DIGITS PROVIDES EARLY EVIDENCE OF VASCULAR IMPAIRMENTS AND THE DIGITS ARE THE IDEAL PORTIONS OF THE BODY TO EXAMINE FOR EVIDENCE OF VASOMOTOR ACTIVITY RESPONDING FROM THE SYMPATHETIC AND PARASYMPATHETIC CONTROLS. Furthermore, many physicians believe that variations in wave amplitude at the individual digits may allude to problems in various areas of the body.

When ischemic patterns are demonstrated in the extremities, many vasodilation procedures are available. The most common is the reactive hyperemic test with the blood pressure cuff application for the differential diagnosis of organic disease process such as atherosclerosis from a functional vasospasm stenotic occlusion due to a neurological disturbance. A most important differentiation for our speciality of treatment.

ARTERIAL AND VENOUS DOPPLER: How accurately can you assess your patient's peripheral circulation? How sure are you that he has deep-vein thrombosis and not a ruptured Baker's cyst? Certainly the history you take and the physical examination you do are important to evaluate suspected peripheral arterial problems. Yet, objective noninvasive testing is an important adjunct, not only for diagnosis, but also for following the course of the condition after prescribed treatment and for prognosing the results of future treatments including, but not limited to spinal subluxation relief, physical therapy applications or internal management by vitamin supplementation. During recent years several noninvasive screening tests have been developed that can greatly increase your ability to evaluate a patient's circulation. For example, they help detect significant carotid artery obstruction in the asymptomatic patient.

Even treatment for the vertebral artery syndrome and the thoracic outlet syndrome can be objectively substantiated, evaluated, and monitored relative to your clinical discipline.

Ultrasound is one of the most important advances in diagnostic medicine since the X-ray. Doppler ultrasound is the most simple, accurate, and versatile of diagnostic screening tests for vascular disease. The Doppler transducer contains a piezoelectric crystal that emits a beam of ultrasound, usually between 5 and 10 megacycles per second (megahertz). The sound is transmitted into the tissues through an acoustic gel on the skin. Sound reflected from moving blood cells is shifted in frequency by an amount proportional to the blood flow velocity. The backscattered ultrasound is received by a second crystal and detected and amplified by the instrument as an audible signal or a recordable analogue wave form.

Normally, arterial blood flow Doppler velocity signals are multiphasic with a prominent systolic sound and one or more diastolic sounds. Abnormal arterial blood flow can be determined by three basic screening tests: wave form analysis of Doppler ultrasound velocity or plethysmographic pulsations; resting ankle and segmental leg systolic blood pressures; and leg pressure or flow responses to exercise or reactive hyperemia.

(Continued on page 25)



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Additional research using azeotropically processed pancreatin have shown it is effective in B12 Absorption, Pancreatic and Gastric Intestines, Chronic Pancreatitis, and Cystic Fibrosis.

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REFERENCES:

¹ Graham, D.Y., Enzyme replacement therapy of exocrine pancreatic insufficiency in man, N. Engl. J. Med., 296, 1314 (1977).

² Bland, Jeffrey, Glandular-Based Food Supplements: Helping to Separate Fact From Fiction 1979-80. (1980).

³ DiMagno, E.P., Comparative Effects of Antacids, Cimetidine and Enteric Coating on the Therapeutic Response to Oral Enzymes in Severe Pancreatic Insufficiency, N. Engl. J. Med., 297, 854-858 (October 20), 1977.

⁴ Gyr, K., Felsenfeld, O., and Zimmerli-Ning, M., The Effect of oral pancreatic enzymes on the intestinal flora of protein deficient Vervet monkeys challenged with *Vibrio cholerae*, Am. J. Clin. Nutr., 32, 1592 (1979).

(Continued from page 23)

Doppler velocity signals from the leg can reveal, distal to an arterial obstruction, the attenuation of the velocity wave form with monophasic systolic pulsation and absence of discrete diastolic sounds.

The resting ankle systolic blood pressure is an excellent screening test for peripheral arterial disease. Normally the resting ankle systolic blood pressure is equal to or slightly above that of the arm. Distal to arterial obstruction, the ankle pressure will be below that of the arm by an amount proportional to the circulatory impairment. Also, Allen's compression studies can be applied distal to a bifurcation to determine the re-routing of the blood flow due to partial or complete stenotic occlusions.

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Again, this procedure does not take the place of a thorough case history, detailed physical examination, EKG, blood chemistries or other related examinations. However, you will find it certainly is an essential armamentarium for the concerned physician desiring to offer his patients the optimum in diagnostic and treating procedures that are available today on an outpatient basis. □

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FUNCTION vs STRUCTURE

By William A. Nelson, D.C.
San Francisco, California

The chiropractic profession was noted at its inception as being a new concept for total health care. Early physicians were proud and diligent in the application of their skills. They were willing to care for any ill of man that did not require surgery, and they would argue with the surgeon over cases he thought were his. A few years ago Levine (1) pointed this out in a lucid article which lamented the fact that many modern DCs are too sophisticated to dare.

Current newspaper articles speak of a new specialty of "family doctor" being introduced. Research leaders are urging greater emphasis on human biological sciences and in-depth studies of health as distinguished from the prevalent study of disease. For 75 years the chiropractic profession has been studying, working toward, and educating in the concept of total health. We have seen public acceptance gradually swing to our belief in such fields as obstetrics, nutrition and, in a few cases, noxious chemicals.

Having pushed for these gains against tremendous odds, even to the point of being jailed for our theories, we stand in jeopardy of losing all. Such a thought may sound irrational but a look at trends in this profession is disquieting. We, who profess total health, are, of all people, entering into areas of specialization. Unfortunately, many of these "specialists" are not considering themselves as general practitioners with a particular liking or skill in one area. They are instead tending to limit themselves to one segment of the body to the exclusion of all else. This is being done at a time when the healing arts are again becoming aware of the unity of the body. All of this works to destroy an image of chiropractic as a complete healing art and substitute an effigy of a limited back discipline. While others are struggling to remove the verdigris from a tarnished image, we must not allow ours to lose its luster.

This profession has stood firmly on the premise that maintenance of the functional integrity of the nervous system is essential to health. The years and acquired scientific knowledge have not modified the basic truth of this tenet. The ACA definition of chiropractic and the U.S. Vocational Guide clearly establish our position. Our concern and our research should then be directed to how best can we affect the nervous system — the basis for our existence.

The vertebral adjustment has been the mainstay for influencing the nervous system over the years. This article is suggesting that we explore other ways of providing therapeutic results within the limitations of our basic premise. As greater biologic and neurologic knowledge is gained, it seems somehow fitting that chiropractic should be able to show the results of its application of modern scientific learning. All disciplines today are expected to advance, yea, are required to advance. The laws of nature are inexorable — evolve or die.

An excellent article by Martin (2) brought to the attention of the field a procedure whereby the functional integrity of an aberrant nervous system could be restored.

This system represents a tremendous breakthrough for our profession and can well be the springboard for great advances in the future. It is a means of using the latest knowledge to quickly and simply accomplish what has heretofore been difficult. This is a total health concept in spite of a deteriorating environment; a principle the public is fearful is becoming lost to the healing arts. An enlightened populace in the late 20th century is no longer willing to accept a questionable drug for symptomatic relief to the detriment of their general health. Their instinct tells them it should be reasonable to expect to feel good when the doctor assures them they are in good health. They are perplexed when told they are now enjoying the best health care in the world, when government statistics belie the statements. The chiropractic physician is advocating a total health conception that they can understand.

Ours is a structure-theorizing, function-practicing profession. We emphasize the subluxation but for years it was a practice to note paravertebral muscle and tissue tension as evidence of the need for adjustment. This procedure still prevails in many offices in spite of more sophisticated means of measuring the anatomical subluxation. Function then becomes the standard of therapy in the final analysis.

Function determines structure. Although for years we have manipulated structure in an effort to influence function, our efforts have not been completely satisfactory. Had satisfaction been obtained there would not have been the need to develop physiotherapy and the rash of pressure techniques recorded in our professional history. Being unable to measure function other than by structure we were caught in the dilemma trapping all the healing arts. The solution was to downgrade function and attempt to improve our influence on structure. This is now being realized as an exercise in futility.

A case in point can be made of examination of the prostate. Digital examination reveals an organ normal in size, shape, and consistency and the physician is prompted to conclude that function must likewise be normal. The diagnosis of functional normalcy is restrained however in this case because the history indicates the patient is up to urinate at least twice nightly. Plainly our diagnosis of function is quite inaccurate when based on the physical examination. It is contended that the same charge can be made against physical examination. If we cannot diagnose function, how are we going to treat malfunction? Obviously, we are not; at least not consistently or by plan.

If function determines structure, then abnormal structure, even though slight, must represent a gross functional aberration of long standing. This is a reasonable theoretical conclusion if we reflect on the long period of time necessary to develop bone and ligament pathology. Viewed from a different stance, although not entirely germane, the organism shows evolutionary changes very slowly in response to changing functional needs.

Scholars have over the years dared to suggest that function was more important than structure. Witness the cobbler bent and deformed over his last, all the while enjoying good health. The ancient Egyptians and Greeks had physicians concerned with function according to Ligeros (3). Mackenzie (4) suffered ignominy from his

(Continued on page 29)

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(Continued from page 27)

colleagues because he had the temerity to suggest that structure was not a reliable guide. He was later vindicated and knighted. Pottenger (5) amplified in California what Mackenzie had started in England. Bennett (6) attempted to interest the chiropractic profession in this thought but he was too early in history. Selye (7) is now encountering the prejudice in his profession previously accorded Bennett. Malmö (8) and others are voicing the growing awareness that better therapy is in the offing.

The worm is turning as evidenced by the growing interest since the publication of the article by Martin. No claim is made that this is the ultimate in advanced functional diagnosis and treatment but it certainly marks a practical approach to a problem plaguing physicians for years. Chiropractic must continue to be in the vanguard for health restoration and disease prevention. Neurovascular dynamics offers an effective tool for accomplishing this now.

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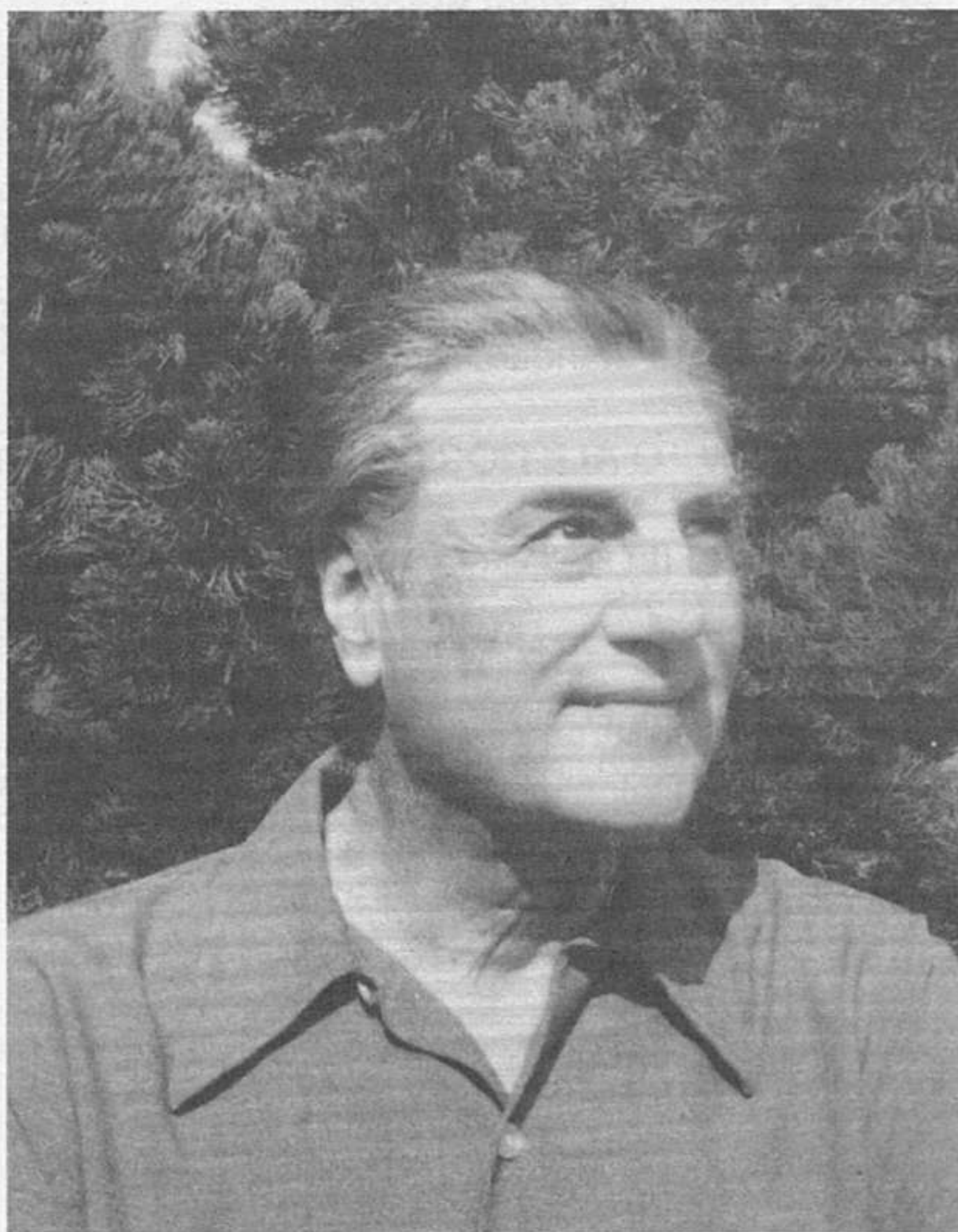
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TRIBUTE LEO E. MONTENEGRO, D.C.

Leo Montenegro is a fighter. He believes strongly in what he does and what the profession can and should do to protect its rights.

To implement his beliefs Dr. Montenegro has been active in both the academic and political areas of his profession for over forty years. In that time he has lectured in various states and taught Chiropractic Jurisprudence and Comparative Therapeutics on several campuses. He has been an officer and on the faculty of three different colleges and also served as a regent for the Los Angeles College of Chiropractic.

Politically, Dr. Montenegro has served as the president of the California Chiropractic Association and as a member and former secretary of the California Board of Chiropractic Examiners. Not content with confining his concerns to the California political scene he has introduced and supported health legislation in other states and nationally.

We may correctly assume from his graduation from the College of Chiropractic Physicians and Surgeons and from the College of Naturopathic Physicians and Surgeons that Dr. Montenegro thinks in broad therapeutic and diagnostic terms. He believes just as strongly that each chiropractic physician should be allowed to practice to the extent of his qualifications, and helped to establish the House of Delegates of the Specialty Societies in California.

Dr. Montenegro is a certified Chiropractic Gynecologist and is a Fellow of the International College of Chiropractic. He brings to the profession his years of knowledge and professional integrity. We're proud to recognize his contributions to the health professions — particularly ours. ☐

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EDITORIAL "A New Year — A Good Future"

by Richard H. Tyler, D.C.

This is the first year of a new decade. At such a time, one is tempted to do like so many these days and come out with a list of predictions to cover the next ten years. Succumbing to this temptation I decided to make a list of things I felt might happen in the not too distant future.

Looking back at some of my editorials over the years, I have noted that much of what I've written has been negative. This can be credited to the ultimate frustration that those of us concerned with a broad diagnostic and therapeutic conceptualization of the profession have had to endure against the intransigence of the straights. Quite frankly, however, I'm as tired of writing about the situation as you might be in reading about it. For so long I've been out of patience with the predictors of doom and here I am, as guilty as those I criticized of that attitude.

Actually, I honestly see a good future for the purveyors of common sense in conservative health care. This is partly because I subscribe to the old-fashioned belief that the good guys always win in the end. You might call it a "Lone Ranger Syndrome." I just find it impossible to believe that in the long run the self-ordained interpreters and protectors of chiropractic can prevail against common sense and pragmatism.

Reinforcing this belief was a visit I recently enjoyed from a young student attending one of the "schools" with "straight" in its name. You know, the one trying to turn out "chiropractic monks." I had expected to hear some wild-eyed dissertation on universal intelligence or the grandeur of a thought that passed through the mind of B.J. Palmer on May 12, 1923. Instead, I sat across the way from a well-educated and thoughtful young man who seemed genuinely concerned about his future! What I heard was that the "school" not only subscribed to the straight philosophy, but to one way of adjusting with no deviations allowed. This had made my young visitor wonder just how there could be only one way to adjust all people, as if we were all alike and could be cured by one magical adjustment. The time has long since passed when a young student with little formal education would sit at the feet of B.J. and accept what he said as gospel. The student now enters a chiropractic school with a solid college background. He's invested too much time, money and energy in his mind to sit passively by while some fanatic espouses unprovable dogma. This is a questioning generation and after a few semesters of dogmatic nonsense one enters a state of either intellectual obedience or most often, an intense desire to escape the madness. According to my friend most of the students opt to escape but are thwarted in most cases, by their inability to transfer credits to better schools. This, in turn, fosters resentment at having been deceived by the "school" into believing that they could readily practice in most states. Caveat emptor.

While I felt sorry for the young man sitting in my office. I must admit to a sense of satisfaction that today's young men and women can indeed be led to some philosophical "water" but cannot be forced to drink.

Therefore, I predict that within this decade:

1. Chiropractic will continue to grow academically.
2. It will accordingly receive greater recognition.
3. It will, out of necessity, recognize a formal schism and formulate two types of licenses.
4. It will develop a dynamic eclectic and conservative professional alternative to the more radical forms of health care.

While I feel encouraged, I am left with one note of sadness. As the student was leaving my office he stated simply that he would have to deny ever speaking with me if he were to be allowed to graduate. Just think — people are teaching classes in the care of the sick, who are so afraid of their students being exposed to divergent thoughts that they threaten them with expulsion. If what you believe is **really** right, then there is nothing to fear from exposure to someone who disagrees. That sums it up, doesn't it?

Happy new decade!



CHIROPRACTIC COLLEGES RECEIVE 1980 GRANT AWARDS FROM THE ANABOLIC FOUNDATION

Dr. Gordon Holman, Chairman of the Grants-Awards Committee, of the Anabolic Foundation, has announced the names of nine (9) chiropractic colleges who have qualified for financial grants under the Anabolic Foundation.

The Grants-Awards Committee, consisting of Dr. Cynthia Preiss, of Glendale, California, and Dr. Gordon Holman, Chairman of the National Board of Examiners, met at the home of Dr. Preiss to review applications submitted by various colleges for grants. The third member of the committee, Mr. William Luckey, editor of Chiropractic Economics, was unable to attend the meeting and submitted his review in writing.

At the conclusion of this meeting, the following colleges were named as recipients of grants:

Canadian Memorial Chiropractic College
Cleveland Chiropractic College
Logan Chiropractic College
Los Angeles College of Chiropractic
National Chiropractic College
New York Chiropractic College
Northwestern Chiropractic College
Texas Chiropractic College
Western States Chiropractic College

In making the awards, Dr. Holman stated that grants were issued for the expressed purpose of providing laboratory, clinical, or teaching aids. Dr. Holman explained that this best accomplished the main goal of the Anabolic Foundation, which is to provide tangible and positive benefits to the many students in chiropractic colleges, rather than a select few.

The profession is indebted to the Anabolic Laboratories and its many representatives throughout the United States and Canada for this assistance program.

BACKACHE — GYNECOLOGICAL

Dr. L. E. Montenegro

Certified Chiropractic Gynecologist

Many women with backache have disturbance or diseases of the pelvic organs. Greenhill states that when retroflexion of the uterus is present in a woman who complains of backache and no other cause for the backache can be discovered, a properly fitting pessary should be inserted in the vagina with or without flexing the uterus into an anterior position. If wearing the pessary relieves the backache and the backache returns when the pessary is removed, there is fairly conclusive proof that the backache is caused by the retroflexed uterus. In preceding centuries, it had been observed that malposition of the uterus had been recognized and treated by manipulation and the use of pessary.

As the nineteenth century progressed, a large number of papers had been written on the subject of malposition of the uterus and its treatment by manipulation and use of the pessary in preceding centuries. Simpson gave an excellent account. He emphasized the general constitutional and local effects of such disorders, pointed out that dysmenorrhea and sterility might occur, and that interference with the functions of the bladder, rectum, and power of locomotion could be expected. He gave a good description of the manner of diagnosing the condition and employed the sound for examination. He has been given the credit for inventing this, but made no such claim and the sound was well known on the Continent in this connection.

Simpson's differential diagnosis involved pregnancy, fibroids, ovarian tumor, pelvic inflammatory disease, ectopic pregnancy, carcinoma, and rectal stricture. Treatment was based upon postural control, rectification of associated conditions (pelvic inflammatory disease), manipulative replacement, and retention with pessaries (either vaginal or intrauterine or both) or the sponge tent.¹

Chapter 19 of OFFICE GYNECOLOGY relates the following pelvic conditions to backache.²

In cases of retroflexion complicated by other abnormalities such as cystocele, rectocele, prolapse of the uterus, pelvic inflammation and tumors, the pain in the back may and usually is due to associated conditions rather than to the retroflexion itself. Correction or removal of the associated conditions nearly always relieves all or most of the backache, even if the operation does not directly involve the uterus.

A second gynecologic disturbance which is frequently regarded as a cause of backache is that which results from injuries during labor. This includes damage to the soft parts resulting in cystocele, rectocele and prolapse and damage to the pelvic joints which brings about separation and abnormal mobility of the sacroiliac joints. Coccygodynia may also result from injury during labor.

The pain caused by cystocele, rectocele and prolapse is nearly always situated in the sacral and lower lumbar regions. Backache is more often associated with cystocele and rectocele than with complete prolapse. Sometimes

a vaginal pessary will prove whether or not a cystocele and rectocele are responsible for backache, but frequently only a repair of the pelvic structures will give this information. A physician should rarely promise that repair of a cystocele and rectocele will cure backache.

The uterosacral ligaments are frequently damaged in childbirth and are common sources of low backache. When these ligaments are injured or inflamed, they are exceedingly tender to the touch. This tenderness may be elicited on bimanual vagino-abdominal examination either by palpating the ligaments themselves or by moving the cervix from side to side. However, a far better way is to make a recto-abdominal examination, by means of which the tender ligaments can easily be detected. The best way to treat tender uterosacral ligaments is by the application of heat through douches, the Elliott or Newman machine, diathermy or other means and also by finger massage.

Dr. Charles H. Wood, in a treatise on internal pelvic massage reported that Major Thure Bradt, a medical officer in the Swedish army, gave a scientific basis for its practice. He pointed out that many European doctors practiced Bradt's method of specific manipulation of the female organs in gynecological problems quite successfully. Dr. Wood found the principle very helpful and successfully used the internal massage techniques of Dr. Miller of Kansas City over many years of practice. "All diseases of the female organs begin with blood stasis and congestion. Gynecological massage disperses chronic inflammations and relieves congestions. Adhesions are broken up and exudates are absorbed. Internal displacements can be corrected by this method and prolapsed tubes and ovaries restored to normal position. Fibroid conditions and cysts can often be relieved by internal massage. I have often completely decongested inflammatory tubal inflammations and have reduced the size of growths in the uterus and tubes."³

He cautions the doctor to always make a very thorough examination before proceeding with this form of treatment. "The patient to be treated by gynecological massage should be placed on a Gynecological table with feet in the stirrups in the classical manner and then the first two fingers of the gloved right hand should be inserted into the vagina; then the fingers should take hold of the cervix of the uterus and a lateral movement, that is to say, vibrating from the right to the left side of the uterus should be done for about two minutes, also the inserted two fingers can massage the tubes and the ovaries as well as the uterus. While the right hand is engaged in manipulation of the vagina the left hand should be placed over the lower abdomen and pressure should be put over the fundus of the uterus so that it can be held firmly."⁴

Dr. Wood reminds his readers that all official treatment is effective because of the well pronounced dilation of the pelvic outlets. He notes that there is also a reflex stimulation of the sympathetic nervous system⁵ together with cerebrospinal nervous system, and that stimulation of the vasomotor system has an effect on the capillary and arterial circulation.

Summing up, Dr. Wood⁶ found that properly applied internal massage reduces and releases all pelvic congestions.

Greenhill, in office Gynecology, points out that "First one must make a careful bimanual examination to be certain that the uterus is retroflexed and the adnexa are normal. In most cases it will be found that the cervix is high up near the anterior vaginal wall. Where the body of the uterus should normally be, nothing is felt because the fingers in the vagina and those of the other hand on the abdomen have nothing between them but the abdominal and vaginal walls.

Manipulative technique is also important in elevation of the body of the uterus from retroflexion to anterlexion, as demonstrated in Figures . . . (53-56), pp. 166-169) Refer to diagrams on pages 29, 30.

References:

- (1) History of Medicine, Cecilia C. Mettler, p. 998.
- (2) Office Gynecology, J.P. Greenhill, B.S., M.D., F.A.C.S., p. 200.
- (3) California Naturopath, Dec. 1945, p. 11.
- (4) California Naturopath, Dec. 1945, p. 20.
- (5) For additional references see: Chiropractic Principles and Technic, Biron, Wells, Houser, RE-Uterus, pp. 161, 283.
- (6) Dr. Charles H. Wood was President and Owner of the Eclectic College of Medicine, which later became the Los Angeles College of Chiropractic. ☐

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CLARIFICATION REGARDING SPINAL ADJUSTMENTS

Ralph J. Martin, D.C.

Early in chiropractic history, there was a deviation from the writings and teaching of D.D. Palmer.* He clearly propounded supremacy of the nervous system over the matters of health and disease. Since he had developed the adjustment of the spine as a discovery for correction of interference with normal functioning of the nervous system, the adjustment became the hallmark of chiropractic. To a large measure the purpose of the adjustment was lost sight of for generations and the "how" of correction of abnormal nervous system functioning by the spinal adjustment crowded out all other factors relating to the purpose of the adjustment. As a matter of fact, it has long been claimed by chiropractic schools and practicing chiropractors that all abnormal functions of the internal organs and glands are caused by subluxations of the spine. If this were true, then as claimed all internal disorders should have been corrected and cured by spinal adjustments. But eager young students going into practice found to their amazement that there were far too many internal disorders that did not respond to spinal adjustments and they did not know what to do about it but to keep on adjusting, as taught.

Too many failures of spinal adjusting started some doctors to not only question but to also start thinking. One idea that developed was that D.D. Palmer must have been right, but somehow we had lost our way in assuming that impulses causing abnormal function and disease came only from the spine to the viscera. What if impulses from the viscera were transmitted through the nervous system to the spine, causing a ponderance of subluxations? This was not really a new idea for D.D. Palmer had discussed it very thoroughly in his conclusion that subluxations were caused by trauma, toxins and autosuggestions (stress). This could mean only that only trauma could be responsible for spinal subluxations which arose in the spine and aroused visceral disfunction. Toxins and stress (autosuggestion) would disturb the viscera and transmit impulses to the spine causing spinal subluxations.

The neurological mechanism involved explained by Houser, in *Visceral Innervation*, Page 24 is that a visceral lesion or malfunction sends a nerve irritation impulse to the anterior horn of the spinal cord which transmits to the posterior horn. There it bifurcates, sending one irritation impulse to the abdominal or thoracic surface area which becomes hypersensitive and another to the spinal nerve root which if long subordinated develops irritation and contraction of the associated intervertebral muscles. This muscle contraction is the force which disturbs the normal position and relationship of the vertebra involved, causing the area to become hypersensitive, and remaining so until the visceral irritation is relieved. The irritation in the viscera is relieved by nerve blocking which consists of contact at the hypersensitive areas of the spine and the abdomen or thorax. When only malfunction is involved, both areas will quickly lose their hypersensitivity.

Bones never go any place by themselves; they are completely inert. Either they are pushed out of normal position by trauma or they are pulled out of normal relationship by contraction of muscles that are attached to them. The source of visceral irritation is either toxins or stress, and only occasionally from subluxations caused by trauma.

D.D. Palmer understood this to its full depth and had the profession not lost sight of these facts, we would not have developed a "cult" image which has so long impaired our public and scientific acceptance.

It should now be clear to all that impulses between spine and viscera are a two-way path — that impulses pass from viscera to the spine and from spine to viscera, and no longer can chiropractic educators or practicing doctors truthfully claim that adjustment of the spine is a cure-all for every human ailment.

This brings us to the really vital question for our times: "What can be done about the correction of abnormal visceral disturbances which transmit to the spine and may produce spinal nerve-root irritations and probably are involved in many spinal subluxations?"

It has been proved clinically for many years that adjustment of spinal subluxations does not correct the majority of visceral disorders. This is not to say that there are no benefits such as balancing sympathetic-parasympathetic systems, stimulating improved movement of lymph and thereby benefiting the function of the body defense system and of stimulating the increased production of interferons to vastly improve defenses of the body against most, if not all, virus invasions. But the influence of spinal adjustments upon visceral disorders is minimal unless the subluxations are caused by trauma which are certainly a small minority of spinal problems. The question of supreme importance is whether it is possible to stop the flow of impulses from visceral disorders to the spine and prevent spinal nerve root irritations and possible subluxations caused from this flow of impulses. From a study of D.D. Palmer's writings, it is clear that he believed that methods could be developed as we learned more about clinical control of the nervous system of the body. He at no point claimed that what he had discovered was the peak and final achievement in health. D.D. Palmer said "There are two classes of chiropractors; those who desire to know all they can about physiology, pathology, neurology and anatomy, and those who have an aversion for intelligence, do not want to take effect into consideration depending only upon examination of the spinous processes." (Page 335) Also, "Chiropractic is a science, it is not a method, the method is the art." (Page 298)

Since Dr. Palmer's time, some clinical progress has been made in learning how to block impulses from disorders of the viscera from irritating spinal nerve roots and prevent or remove subluxations which are associated with visceral disorders. This is done entirely through nerve control without moving vertebra or any form of forceful adjusting. This does not mean that I am opposed to spinal adjustments. On the contrary, in practice I adjust almost every patient, but only for strictly musculo-skeletal lesions. It is the very first thing I do but it is only the beginning of a good complete treatment in which we restore harmony throughout the entire body. The adjustment must involve selectivity, expertise, and artistic execution plus full realization of what it cannot be expected to accomplish.

After the adjustment we have the patient lie supine on a completely comfortable table. By checking precise surface areas, we first determine whether the patient is in shock. If they are found to be in this state of imbalance between the sympathetics and parasympathetics we hold specific points until parasympathetic hypersensitivity is released, then proceed to check out all specific visceral area surface points against the celiac area of the spine, dorsals 4, 5, and 6. "Each portion of the body is under the control of 'nerve centers' located in the brain and spinal cord." (P. 34 D.D. Palmer) All visceral areas below the diaphragm have nerves passing through the celiac plexus. If the tissue lying over the celiac plexus is hypersensitive to palpating mild pressure, some abdominal viscera is not functioning normally. As soon as sensitivity is alleviated at the celiac plexus, all viscera are again functioning normally and all surface areas are no longer hypersensitive. They are soft, relaxed and comfortable.

If the tissue over the laminae of D-1 and 2 are hypersensitive there is abnormal functioning in either the heart or lungs or a stress accumulation in the supra spinatus and trapezius muscles. This accounts for most cases of brachial neuritis except those caused by specific trauma or visceral disturbances, such as gall bladder malfunction. (Trauma includes lesions of the first three ribs which have lost their normal articulation with the spine). This spinal area is held with a finger-tip contact until all tenderness is removed from lung, heart and supra spinatus contacts. Our neurovascular dynamic treatments begin on the left side of the patient, then the right side and finally finish with brain areas which is another subject, but we must never lose sight of the fact that whatever "Innate" is, it functions through the brain and utilizes the brain as the master "imitator" and "coordinator" of everything within and about the whole person.

However, it must not be overlooked that we have not yet completed consideration of the visceral areas for we have these areas which are located on the face and have to be used with a "reaction potential" either by stretching the trapezius muscle or contact on either side of the cervical ganglion at D1-2. These are pituitary, carotid sinus, parotid gland, eyes and thyroid gland. These are on both sides and are shown on the chart. We have clinically experienced the vital importance of treating these areas routinely for it is not immediately possible to identify their influence from the symptom complex presented. Productive utilization calls for careful textbook review of the functions of these organs and glands which will provide insight for therapeutic application. Without such knowledge and insight, time spent on these areas would be an exercise in futility. *(The Science, Art and Philosophy of Chiropractic. D.D. Palmer) ☐

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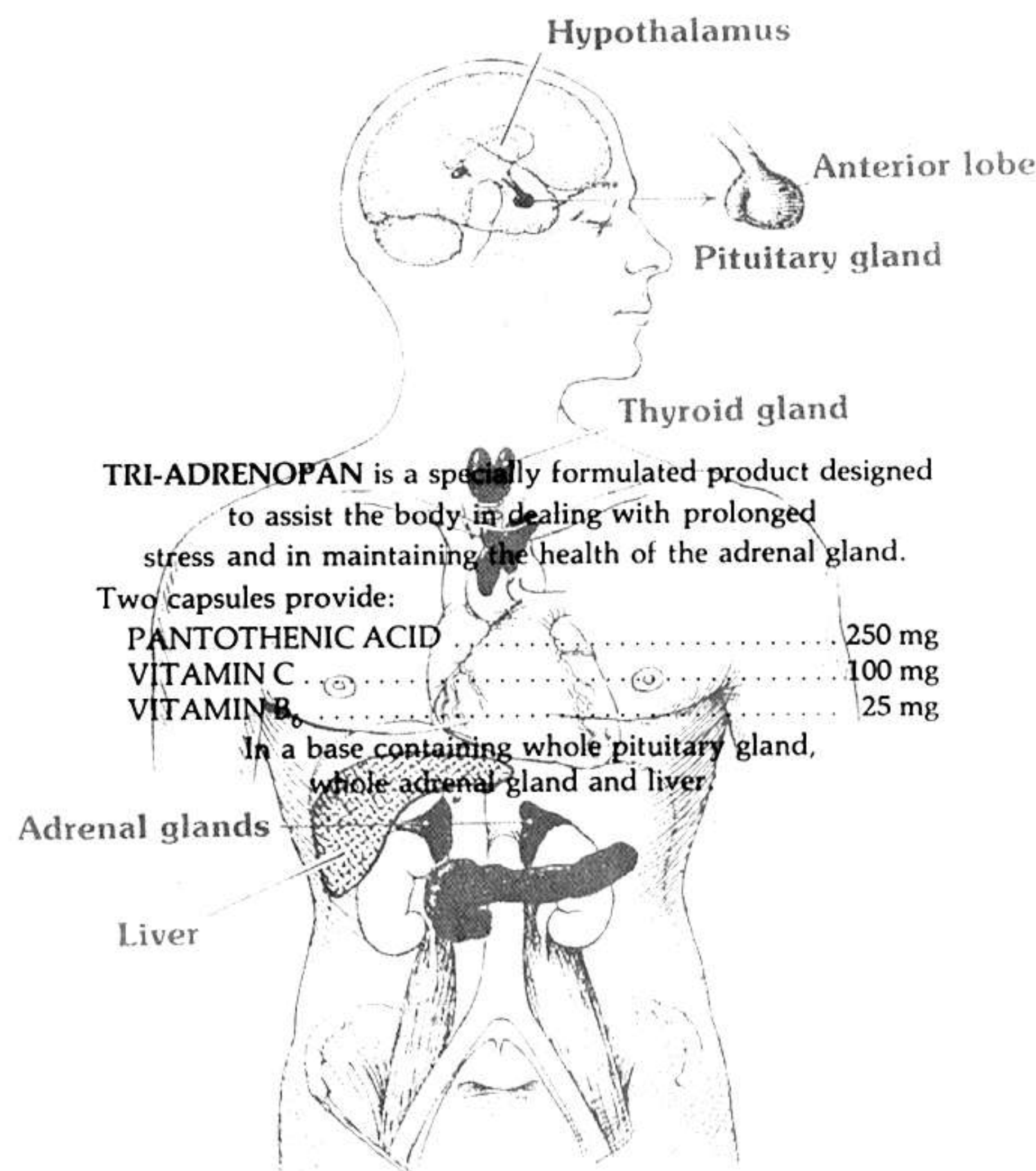
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Clinical Roundtable CASE HISTORY — Female, Age 24

by Dr. Donald W. Nelson, D.C.

R.J. is a young, very attractive lady first referred to me in January 1980. In November 1979 as a "bagger" for a local grocery store she occasionally had to lift 60# of paper bags to fill checkstands. At this time she had lifted this weight and twisted-turned her body to the right. A left lumbosacral sprain/strain with radiating pain into the left leg and foot resulted. Her M.D. prescribed diathermy and muscle relaxants. Two months later after slight improvement she came to me. We treated with spinal manipulation (LACC specific) and NVD (Neurovascular Dynamics acupuncture-physiologic precursor to Applied Kinesiology). The spinal manipulation focused on the lumbosacral region; the NVD released functional organic disturbances centralized in her lower digestive tract. R.J. likes her dairy products in excess and over the years a toxic state had developed in this region. By the middle of February she was "discharged as cured" — 3 weeks after initial consultation, history, examination, and X-rays.

In the middle of August 1980 she repeats a similar injury. This time it is moderate-severe in the low back as compared to moderate in January. Our history reveals continued excessive dairy intake (she states not as much) and fried foods, headaches, prolonged periods and worsened cramping, and familial tension with her sister. We find her birth control pill history dates back 6 years. We again duly advise her on dietary habits, her stress, and then proceed to investigate "the pill" situation through our mutual concern. *(continued on page 16)*



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R.J. wants to stop "the pill" but can't decide what to do and is essentially fearful of pregnancy. We talk about this and reassure her the diaphragm would be the safest overall — though pregnancy risk is slightly higher. She opts for the diaphragm and immediately her whole personality seems to change. Now she is more relaxed and no health paranoia is evident. Also, her boyfriend of several years does not have to undergo a vasectomy operation though it doesn't matter to him (having fathered children from a previous marriage). I might add that R.J. would like to have children sometime in the future. By the 3rd week in September she is fully recovered.

No disability her first injury: 2nd injury off work 3 weeks. More referrals to me from this satisfied patient have resulted. She understands better after the 2nd injury the importance of good diet and handling stress. We discussed the probability that 60# may be too much for her to lift — at least for awhile and recommended she be cautious in considering lifting this much weight again.

Most importantly, R.J. has had the opportunity to take her health in her own hands. I encourage this in my practice using my knowledge/experience as a guiding rule. R.J.'s female health is now stabilizing; her digestive health will continue to improve; and, lastly, her self-confidence in herself and her body's natural healing strength has vastly improved. She knows she now has control physically and mentally. I hope her spiritual strength becomes as strong. If it does she will have no further major problems.

Author Profile:

Dr. Don Nelson grew up in a Chiropractic family. His father Dr. Bill Nelson and his brother Kim practice in San Francisco. Dr. Bill is a Chiropractic Internist and the Executive Director of the Council on Diagnosis and Internal Disorders of the ACA. Dr. Don is a Council Member and utilizes spinal manipulation and NVD (Neurovascular Dynamics as propounded by the former Dr. Terence Bennett, D.C.). Many of Dr. Nelson's patients recover from ailments and continue maintenance Chiropractic care for their well-being for their remaining decades. Dr. Don in his Eureka, California practice does accept strictly musculoskeletal conditions as well, reluctantly. ☐



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COUNCIL on DIAGNOSIS MEMBERSHIP of 2000 to 5000 — WHY NOT?

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As we proceed into the 1980s, more than ever before we will be watched . . . by the press, by congressmen, senators, executive bureaucrats and Federal policy makers at all levels, not only for what we 'say' but more importantly 'what we do.' As we are listed as "portal of entry practitioners into the health services . . . as primary providers" we will be constantly watched to see if we continue to qualify to remain in this classification.

If membership in this Council on Diagnosis remains at 500 or less, we can expect little red flags going up in Federal files indicating some question as to our truly responsible interest and commitment to diagnosis. For 'portal of entry' practitioners Diagnosis is our first and greatest responsibility. Unless we can competently meet this primary step the patient may be processed or referred for the wrong specialty for the wrong treatment. Records must substantiate our entitlement to retain through competent diagnosis the status we have achieved. The other Councils are Specialties, but Diagnosis is the foundation and floor under all of them and we invite them to join with our members in making a visible dedication to diagnosis and thereby strengthen our professional status.

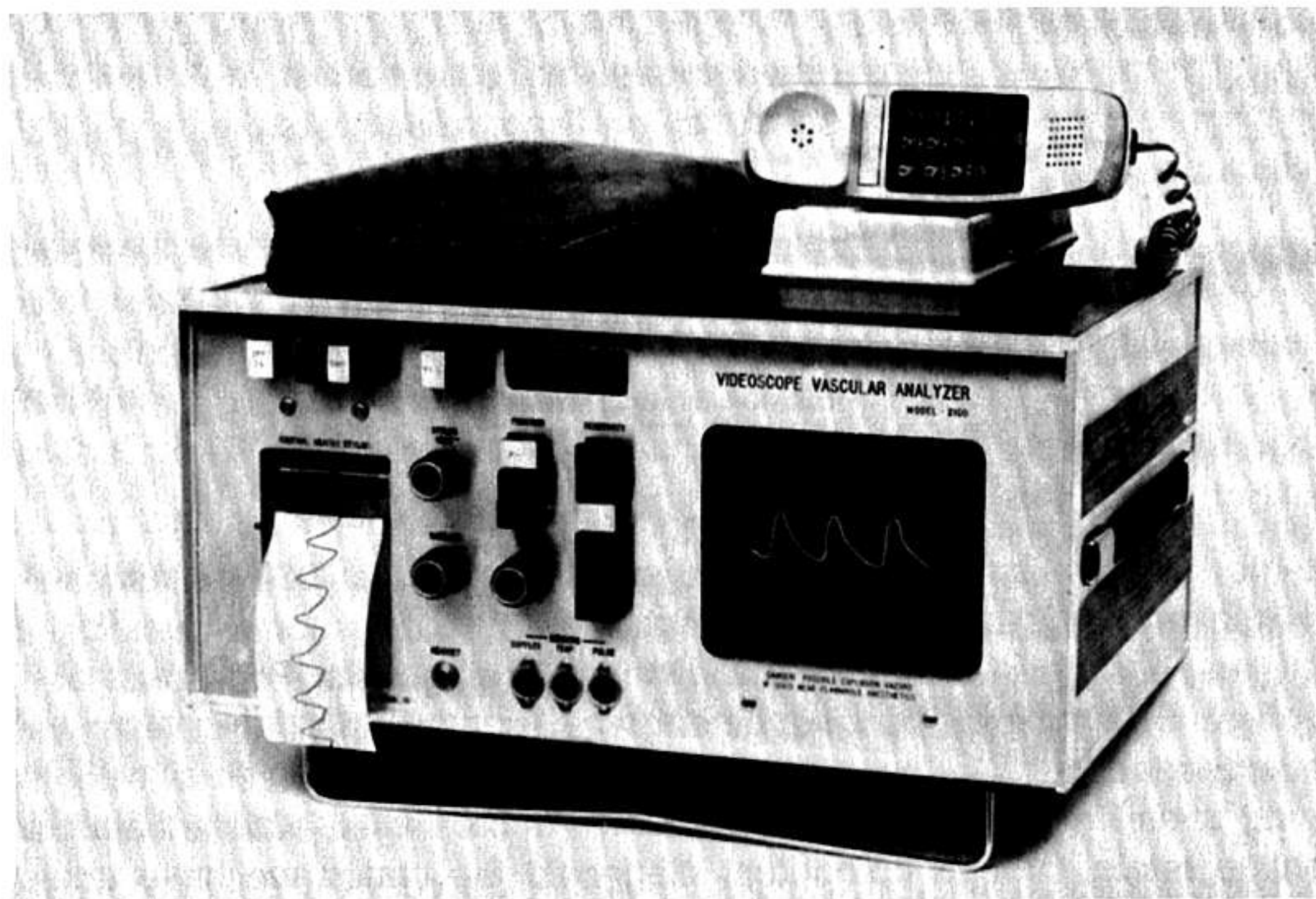
I submit to you that ACA's and C.C.E.s 'clout' with Federal agencies will be tremendously enhanced when the membership in this Council on Diagnosis is numbered in the thousands . . . not 500 or less.

Doctor . . . think not of what ACA and C.C.E. can do for you, but much more what YOU CAN DO to enhance and strengthen their representation of your interests! What better for a start than to become a sustaining member of this Council and also interest and enlist your colleagues in becoming members. Just imagine the enormous support that a membership of 2000 to 5000 in this Council on Diagnosis would provide our offices in Washington, D.C.. This is only the first step, but what a tremendous step this would be, and consider how it would answer effectively any inquiring agency questioning whether our people are really committed to concern about diagnosis as we function as primary providers.

Doctors, lets get on with it and take this first step to make this Council on Diagnosis large enough to convince any Federal investigators that we are committed to Diagnosis . . . Absolutely! ☐

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VASCULAR DISEASE and the CHIROPRACTIC PHYSICIAN

Warren F. Jahn, D.C.

A study of blood vessels of the extremities cannot be considered apart from the neuromusculoskeletal system. The chiropractic physician must be proficient at identifying and interpreting the state of the circulation in the extremities.

"Inadequate blood flow must be differentiated from musculoskeletal disease as a source of symptoms."¹ "There are somatic components of visceral disease, symptom complexes from musculoskeletal causes that mimic visceral disease, and visceral disease that may simply mimic a musculoskeletal symptom."²

"There are several important reasons for paying close attention to the peripheral arterial circulation.

1. Peripheral arterial disease can be routinely diagnosed before dire consequences have occurred so that corrective and preventive measures can be taken.
2. The presence of diseased peripheral arteries may offer a clue to the presence of arterial insufficiency in other locations."³

The study of peripheral disease, as a discipline, has been a relatively neglected field, considering the frequency of the disorders that it includes. Few clinicians have been interested in peripheral vascular disease, and peripheral vascular physiologists are even scarcer. Much of the difficulty in stimulating broader participation of peripheral vascular disease has been related to the difficulty in the defining objective terms in the functional severity of the various arterial and venous disorders. Techniques for such measurements, until recent years, have been complicated, cumbersome, and so time-consuming that they were of little use to the clinician despite their research value.

Muscular disorders, arthritis of the knees and hips, degenerative disease of the spine, bursal inflammation, peripheral neuropathy, foot strain and painful osteoporosis are some of the conditions that may be confused with primary circulatory disturbances. The practicing chiropractic physician now has available to him, either in his office or in community hospitals or clinic, several inexpensive, simple instruments to aid in recognizing and properly referring or treating patients with vascular disease.

The dilemma of inadequate physician education in these diseases, however, must not be overlooked, and every effort should be made by chiropractic educators to implement the teaching of the peripheral diseases as an integrated specialty, both at the undergraduate and postgraduate levels. The application and the interpretation of doppler ultrasound and plethysmography studies is currently taught at National College in their course on cardiovascular and respiratory disorders (DX 6531), with practical application in their clinics. National College also has a postgraduate course in peripheral disorders. It must be emphasized that if you are going to undertake such a procedure as part of your diagnostic regime then the appropriate qualifications and background must be obtained from an approved CCE accredited program.

In the course of the physical examination, there are many reliable tests and clinical signs that would confirm or deny the existence of a vascular syndrome. Vascular instrumentation is a most reliable adjunct to clinical examination and supplements some of our simple reliable tests. Vascular instrumentation cannot be used as a sole differentiating objective finding between neurological and vascular disease states. The physical examination should include all the necessary documentation and clinical procedures that would warrant and lead us to the use of vascular instrumentation as a means of substantiating our initial diagnosis or impressions. There must be some strong indications from the history as well as clinical objective findings to warrant ordering a vascular workup. I have written an article entitled, "Clinical Examination Procedures for Suspected Vascular Disease" which was published in the ACA Journal, December 1980, Vol. 17, No. 12. This article was written to begin the accumulation of clinical guidelines for the primary care physician.

A variety of instruments that permit evaluation of peripheral arterial and venous diseases are available. They make possible an assessment of variables related to the pathophysiology of disease which affects the vessels. Such variables include systolic pressure of the limbs, limb blood flow, flow velocity, direction of flow and volume changes of limbs.

I. Plethysmography: Plethysmography is the graphic measurement of volume change.

II. Pulse volume recorder: "Pulsed volume recorder is a quantitative segmental plethysmograph designed for high sensitivity and clinical application."⁵

NOTE: The difference between the pulsed volume recorder and the plethysmograph (photopneumo, etc.), is that the plethysmograph measures and records the size of a body part as modified by the circulation of the blood in that part. The pulse volume recorder measures the pulse flow changes, not the size of the body part."⁶

III. Ultrasound: "Ultrasound is one of the most important advances in diagnostic medicine since the x-ray. Doppler ultrasound is the most simple, accurate and versatile of diagnostic screening tests of peripheral vascular disease. The Doppler transducer contains a piezoelectric crystal that emits a beam of ultrasound usually between 5 and 10 megacycles per second (megahertz). The sound is transmitted into the tissues through an acoustic gel on the skin. Sound reflected from the moving blood cells is shifted in frequency by an amount proportional to the blood flow velocity. The back scattered ultrasound is received by a second crystal and detected and amplified by the instrument as an audible or a recordable analogue way form."⁷

"Measurements of systolic pressure, which can be performed by noninvasive methods easily and repeatedly support a quantitative, objective and sensitive index of occlusive process and complements the information obtained by clinical assessment and, where appropriate, by angiography."⁸

IV. Arteriography (angiography): Contrast angiography is a means of visualizing the lumen of the arterial tree in the abdomen and limbs, generally by means of intra-arterial injection of the radiopaque medium followed by roentgenology.

Expectations for evolving noninvasive techniques follow:

1. Addition of objectivity to clinical observations.
2. Replacement of current indirect diagnostic procedures, for example, lumbar spine x-ray film for the diagnosis of abdominal aortic aneurysms.
3. Improvement and selection of patients for angiography.
4. Provision for needed natural history data on certain vascular diseases.
5. Prediction of the outcome of therapeutic measures.
6. Availability of serial measurements for evaluation of therapy.
7. Capability of mass screening not currently possible.
8. Heightened interest by the profession in peripheral vascular disease.

There is much confusion throughout the profession on whether vascular instrumentation falls within the scope of the chiropractic physician. National College of Chiropractic in their position paper entitled, "Evaluation of the peripheral vascular bed by the chiropractic general practitioner as taught and used by the National College of Chiropractic," state: "evaluation of the peripheral vascular system is within the scope of general chiropractic practice and is recommended whenever the doctor has reason to suspect vascular dysfunction. The general methods of evaluation have been outlined, however, it must be emphasized that in many cases simple preliminary studies may obviate the need for further more expensive testing. Contrariwise, in many instances, there is a need for specialty consultation. The general chiropractic physician must assess the limitations of his training and experience and the limitations of his diagnostic instruments." It must be emphasized here that the instrument is not being questioned as it relates to diagnosis but for its use to prove the efficacy of manipulative therapy which falls into the realm of research. Many State Associations and Peer Review Groups are taking the position that since the colleges are performing clinical investigative studies using these instruments that they are not of any diagnostic value. This is a fallacious approach since they recognize and use it in the clinics such as at National College for its diagnostic value. Potential into research into all phases of peripheral vascular disease in the future is enormous. Every effort should be made by our colleges and the council on diagnosis and internal disorders of the ACA, to implement advanced instruction of peripheral vascular diseases as an integrated specialty and future clinical investigative studies performed to demonstrate the efficacy of chiropractic therapy in vascular disease.

The spectrum of physicians who encounter patients with vascular diseases whether it is primary or secondary is indeed a broad one. It includes the primary care physician, the internist, the cardiologist, the orthopaedist, the neurologist and the surgeon. Patients seen by this group of physicians are referred to the vascular surgeons for the diagnosis or proposed therapy due to a lack of understanding, education, or apprehension regarding vascular disease.

Readily available testing procedures that can substantiate the diagnosis and further provide a basis for follow-up care are invaluable to the primary care physician. Basically, it is no different from ordering any other diagnostic procedure, whenever clinically warranted.

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BOOK REVIEW

CHIROPRACTIC PHYSICAL AND SPINAL DIAGNOSIS

by R.C. Schafer, D.C., F.I.C.C.

This book is a monumental tribute to the chiropractic profession. It represents the culmination of a cooperative effort between the editor, the CCE colleges and members of the profession that bespeaks a profound professional dedication.

A volume of 574, 8½ x 11 hard-bound pages places this book on a scale with the best in your library. Amply supplied with drawings and photographs it presents diagnosis with a chiropractic flavor.

While diagnosis is considered the same for all disciplines, the chiropractic approach is unique. Traditionally, because of our emphasis on the nervous system, we tend to be very conscious of the whole person. To read the preface is a joy as the chiropractic editor lays it on the line and clearly explains that the chiropractic holistic approach, while different, is none the less valid.

The introduction covers the broad scope of diagnosis with suitable recognition to D.D. Palmer as well as reminding the reader that chiropractic procedures are a vital part of the whole subject of diagnosis.

Chapter I, Body Habitus: The Patient as a Whole again emphasizes our concern with balance, posture, muscle tone and body mechanics. All the way through traditional procedures are tied in with chiropractic procedures and a useful homogeny is the result.

Each subsequent chapter covers a particular area of the body but with chiropractic concerns added to conventional diagnosis making an approach that transcends the traditional. Every chiropractic physician will profit from occasional references for the wealth of information contained is great.

A significant departure from the usual diagnostic texts is the addition of a chapter on Basic Musculoskeletal Considerations and one on Basic Neurologic Considerations. Whether your interest is orthopedic, neurologic or just soft tissue such as used by kinesiologists, you will find these chapters exciting and thought provoking.

The editor has made a determined effort to have this book the most authentic possible. Nine full pages of bibliography, a major portion from chiropractic publications, attests to the depth of research used in compiling this text. To read the number of fine chiropractic titles that have contributed makes one realize chiropractic has taken its place in the scientific community. All in all this volume should be in every chiropractor's library. It will be used and used and used.

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William A. Nelson, D.C.



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Dear Ralph:

As you know, my recent article about laboratory diagnosis pointed out many of the pitfalls that are to be found in various laboratory tests.

Ralph, I really believe that in the chiropractic profession there are a certain percentage of chiropractors that are working and fighting very diligently for the RIGHT to use laboratory diagnostic procedures. I am quite concerned as to their motive. These laboratory tests are simply not that conclusive.

For example, it seems to me to be quite ironic that in the same issue of The Chiropractic Family Physician that my article appeared there was a short article by Richard H. Tyler, D.C. wherein he advocates the use of various laboratory tests for the diagnosis of renal and or hepatic disease. Then, just the other day I received the September issue of the Blue Shield of California Medicare Bulletin. On page 3 of this bulletin there appears a list of "Diagnostic Tests Found to be Obsolete or Unreliable." Included in this list are two of the tests that Dr. Tyler recommended in his article! The cephalin flocculation test and the thymol turbidity test.

The textbook that was used when I attended LACC was "Clinical Pathology" by Wells, third edition, published by W.B. Saunders Co. in 1962. Both of the aforementioned tests are discussed in this text. And now, here we are, eighteen years later in the stream of time and these tests, which have been used for years and years, are now considered to be 'obsolete or unreliable.'

If we are going to do a credible job for our patients and for the profession, we have to do more than just be advocates for the same routine of laboratory tests that the patients have already been through with their M.D.'s. It is incumbent upon us as a profession to investigate these tests thoroughly and completely as to their clinical accuracy and meaning before we simply take them out of the textbooks and recommend their use.

Ralph, you may use this as a Letter to the Editor if you think it would be appropriate.

Sincerely,
Andrew R. Jessen, D.C.

Editor's Comments:

... and it has recently been disclosed that the AMA doesn't believe yearly physical examinations are needed ... and the value of pap smears is presently under contention. We could go on but the point is made that all of the tools used to diagnose and treat in any of the healing arts are in a constant state of reevaluation and change. The only "motive" we all should have is in giving a comprehensive and meaningful examination to our patients. The art of diagnosis is capricious at best. It is difficult to keep abreast of all the changes and revisions constantly being made and just about impossible to anticipate them. I shall keep my eyes open for the next Blue Shield of California Medical Bulletin — while perhaps not as breathlessly as some, at least with interest.

Dear Dr. Tyler:

The article written by Dr. L.D. Godwin, titled "Chiropractic Weaknesses," points out certain problem areas that our profession does endure at this point in time. It is my opinion that the approach utilized by Dr. Godwin lacks in good taste.

P.S. Is Dr. Godwin a member of the Council on Diagnosis and Internal Disorders?

Respectfully yours,
James J. Lehman, D.C.

Dear Dr. Tyler:

May I compliment you on your fairmindedness and courage in giving publication to the excellent article "Chiropractic Weakness" by Leonard Godwin in your November issue.

Never in my 46 years of practice of chiropractic have I experienced the pleasure of reading someone in the profession who has had the courage to say what had to be said, openly and publicly. And, might I again add, congratulations to a publisher who has had the intestinal fortitude to espouse such an expose. Perhaps there is still hope for chiropractic as long as we have the men (persons) of the caliber of Drs. Tyler and Godwin; those who possess the sincere desire to leave this world a better place for their having travelled through.

In his 12 point critique I believe Dr. Godwin accomplishes more for chiropractic than all the purveyors of questionable seminars by self-appointed experts, instruments and as he so aptly puts it, "cattle shoots" et al. It gives me a genuine sense of elan to read such honesty instead of the constant diatribe anti medical doctors, hospitals, drugs etc.; let's leave that to the likes of Mendlesohn and those more qualified to comment on their own. I, for one, would dislike very much to live in a world devoid of sincere physicians (of whom there are many), hospitals, drugs and surgery. When one emerges from the paucity of knowledge, the benefits are obvious.

I believe the article described should be published openly in our National Chiropractic media, if they have the courage to do so!!

In essence, I believe he means to convey that the trouble is not with chiropractic but with chiropractors in many instances, with which I agree whole heartedly. And if it is as reported recently that medicine may take over chiropractic in Europe, chiropractors will have paved the way. But chiropractic technique will live because of its efficacy even if under the name of medical manipulation or what have you.

I am grateful to Dr. Ernest J. Smith of Santa Cruz for sending me a copy of your interesting magazine.

Sincerely yours,
Charles J. Bucknell, D.C.

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We strongly urge that everyone who has the "Dynamics of Correction of Abnormal Function" should purchase the three paper back books. There are so many marvelous services that can be accomplished by chiropractors with the knowledge contained in these books . . . you just cannot imagine what you are missing.

After there has been a somewhat wider distribution of these books we may be able to put on classes in various parts of the country again. There is an increasing demand for such classes and some specific areas are now being considered. Prior familiarity with the contents of these books will make class attendance much more productive for each of you. There are untold numbers of people who will get no help anywhere unless we provide it for them, and we can surely provide much help when we have the know-how.



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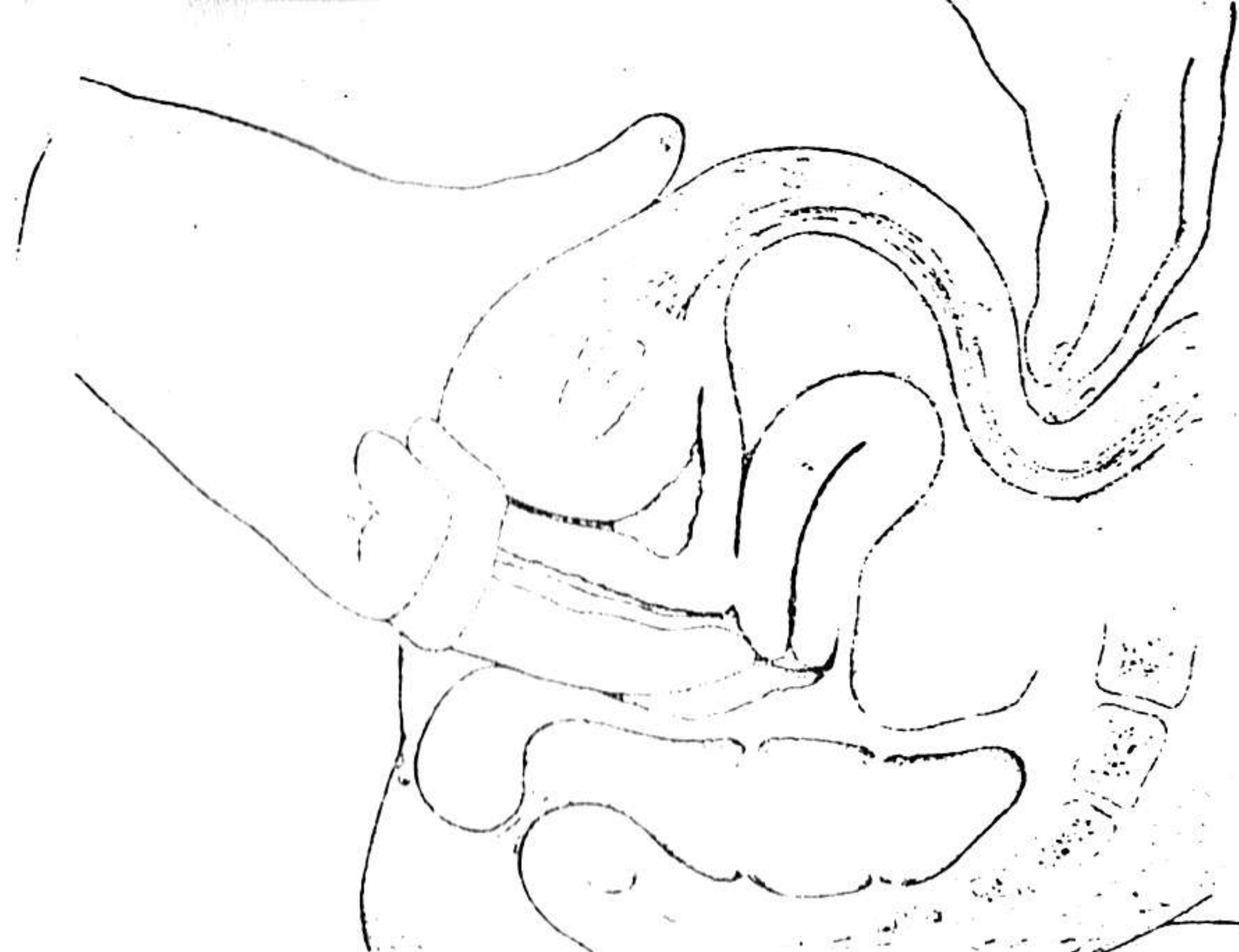


Fig. 53. Elevation of retroflexed uterus. First step. Fundus is gently pushed out of culdesac.



Fig. 54. Elevation of uterus. Second step. Fundus is straightened out.

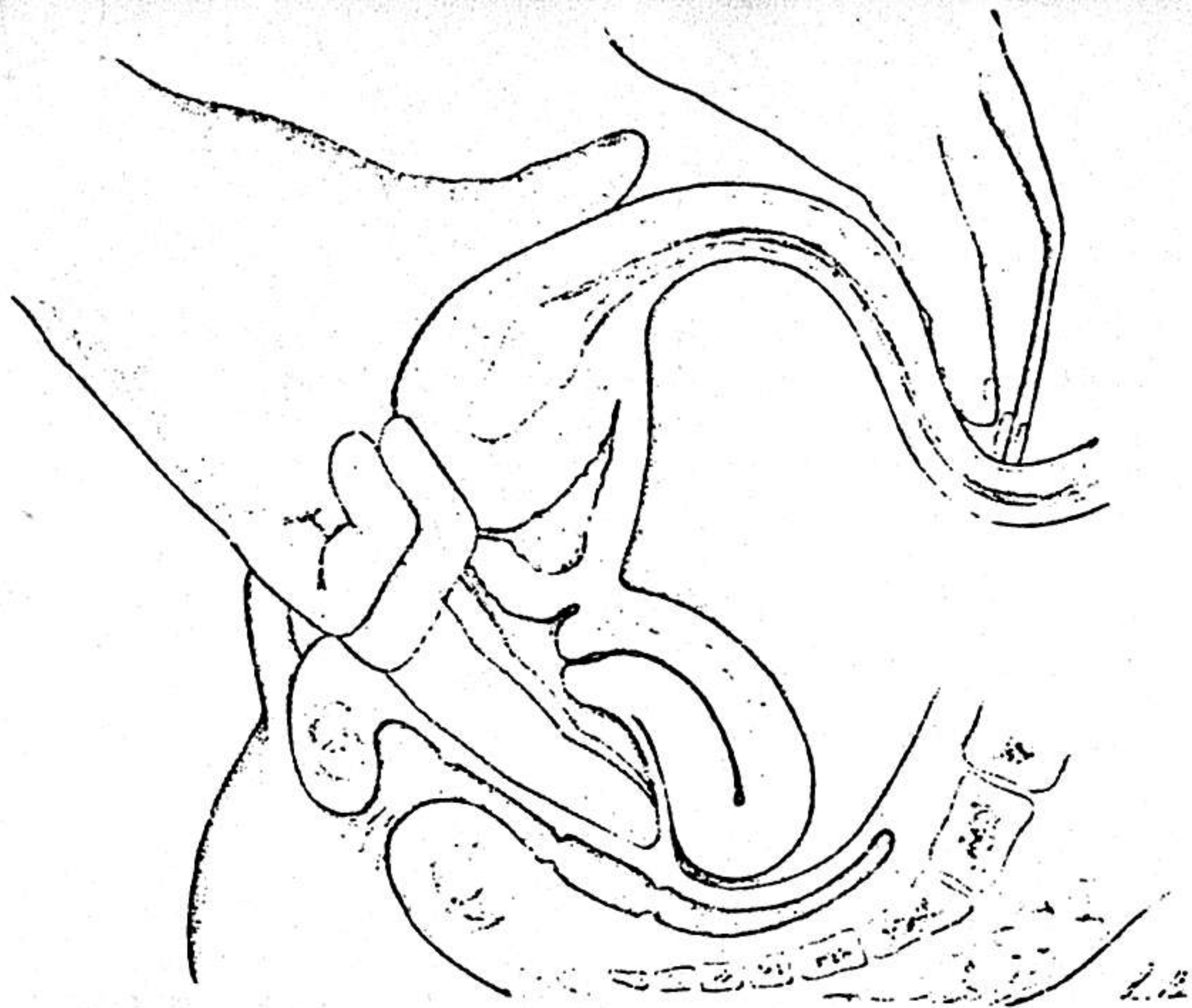


Fig. 55. Elevation of uterus. Third step. Fundus is brought up.

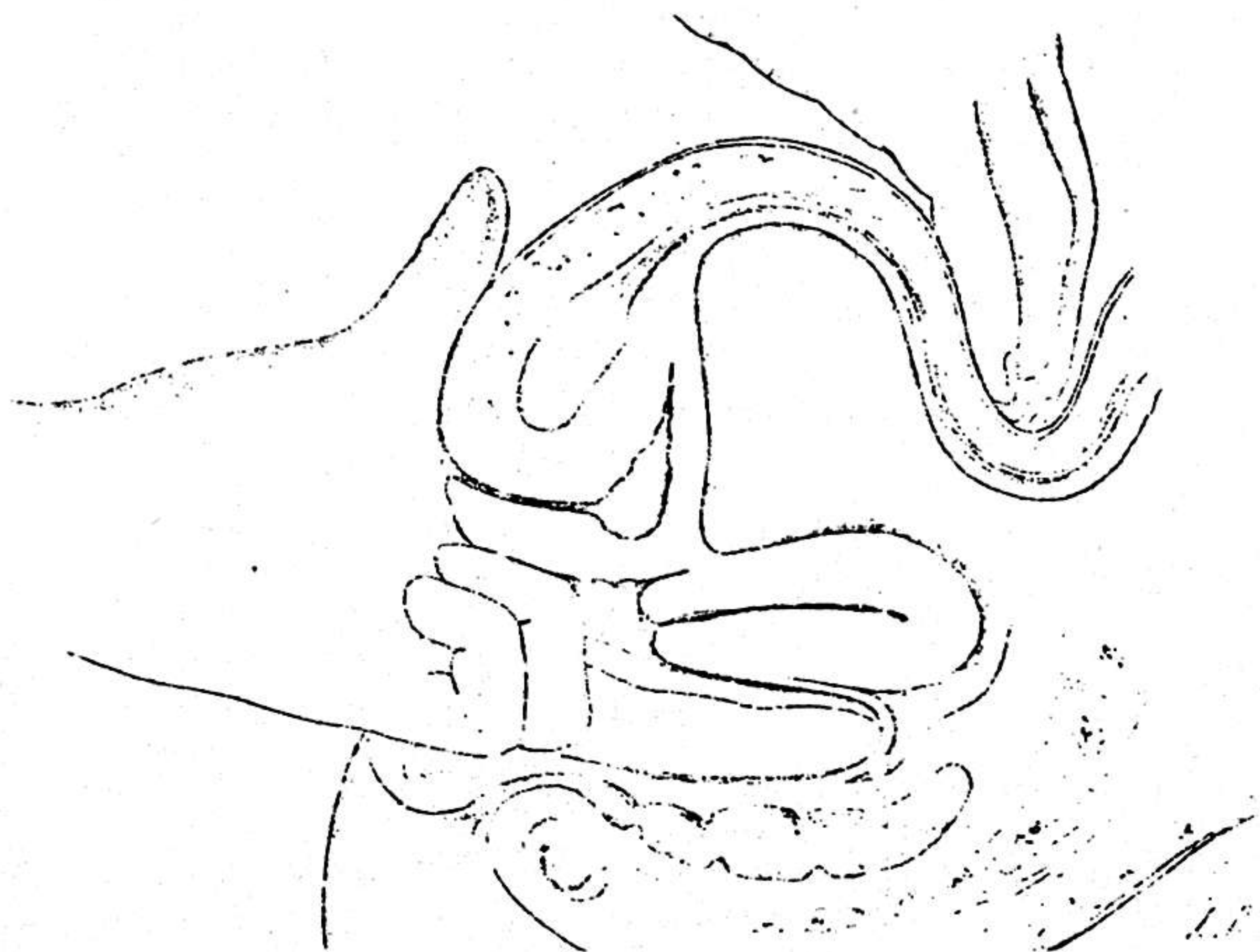


Fig. 56. Elevation of uterus. Fourth step. Uterus is sharply anteflexed and maintained in this position by outside hand.

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THE CHIROPRACTIC FAMILY PHYSICIAN

JUNE, 1981

VOL. 3, NO. 4



DR. RICHARD C. SCHAFER

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the Chiropractic FAMILY PHYSICIAN

JUNE, 1981

VOL. 3 NO. 4

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The binding of the book on a shelf in my office boldly proclaims in gold letters "Chiropractic Diagnosis." It is a prized possession for the contents are the sum and total of the title. It is a bold and uncompromising text drawing from diverse examining procedures to become a compendium of varied diagnostic concepts. It is one of the most important texts to be published in the chiropractic profession.

The man responsible for "Chiropractic Physical and Spinal Diagnosis" is the same one who authored/edited "Basic Chiropractic Procedural Manual" (1 through 3 editions), "Basic Chiropractic Paraprofessional Manual," "Chiropractic Health Care" (1 through 4 editions) and "Opportunities in Chiropractic Health Care." Dr. Richard Schafer is presently developing a new text entitled "Chiropractic Management of Sports and Recreational Injuries."

Since July of 1979, Dr. Schafer has served as the president and executive editor of Associated Chiropractic Academic Press (ACAP) which is concerned with the development of clinical and professional literature for the chiropractic profession. Prior to this commitment he served as the director of Public Affairs for the ACA. Among his many accomplishments in this position was the increase in public service announcements on radio and television from \$130,000 in 1973 to over \$5,300,000 in 1976. Prior to his ACA association, Dr. Schafer served as the president of the Behavioral Research Foundation which was concerned with professional research and development.

The depth of Dr. Schafer's research and editing skills was demonstrated in the late 1960's when, within a year, he was promoted from assistant editor, to editor, to editor/assistant manager of the Southwest Research Institute of San Antonio, Texas. The institute is one of the largest research organizations in the United States. Also during the 1960's, Dr. Schafer owned a publishing house which specialized in the development of material dealing with increasing personnel performance and morale.

Dr. Schafer earned his chiropractic degree from Lincoln Chiropractic College. He also holds a Bachelor of Science degree and is currently engaged in obtaining a doctorate in psychology. He is a fellow of the International College of Chiropractic, a founding member of the Association for the History of Chiropractic, listed in "Who's Who in Chiropractic," and a member of the ACA councils on Diagnosis and Internal Disorders, Mental Health, Nutrition, Orthopedics, Sports Injuries and Technic.

The space just doesn't exist to list all of the accomplishments of this author, editor, lecturer and physician. The testimony to his dedication and skill, however, is forever recorded in his brilliant literary gifts to the profession he has served so well. □

EDITORIAL "The Summer Soldier" by Richard H. Tyler, D.C.

How many times have I seen the dilated pupils and flaring nostrils of the born again straight chiropractor. In my office I've encountered them. On the streets, in the schools and at seminars I've encountered them. And the letters — the garbage I've received and the telephone calls I've had. I never knew so much hate could be spewed by such a sanctimonious lot. Admittedly, they are a minority. Probably a very small one. However, they make themselves heard by the sheer volume of their rhetoric.

To the uninformed layman this vociferous segment of chiropractic represents the entire profession simply because it's the *only* voice they have heard. What makes it worse is that the straights would have us all practice as they do. They think of themselves as the "keepers of the flame." They are the priests in the temple of chiropractic and they won't tolerate what they might consider heresy.

If we on the eclectic side are heard it is because there are so many of us. By the sheer weight of numbers and work of a dedicated few, we can still practice with some measure of freedom. As the saying goes, however, "The price of liberty is eternal vigilance." Unfortunately the silent majority is so silent that we sometimes think that the voice is gone. This is why we publish this journal. We try to articulate the ideas of so many in our profession. Sometimes we seem to be the only ones doing the speaking. We look around and see a lot nodding in agreement, but not a sound is heard.

The "sound" I'm referring to comes in many forms. The most viable is found in support for the continued growth and implementation of a broad scope practice by joining the Council on Diagnosis and Internal Disorders. How many of you bothering to read this have taken the time to join the council? Certainly some have, but the vast majority of the thousands who receive this publication are apparently those content to nod in agreement but do nothing more.

As a result of the aforementioned attitude, it is my sad duty to inform you that this might be the last issue of the Chiropractic Family Physician. While this has been a labor of love, mainly sculptured and built by Dr. Ralph Martin, it unfortunately takes more than love to pay the bills. With increased printing costs and rising postal rates it has become impossible to maintain the quality of this publication and still print it. Rather than sacrifice the content and the message it carries, it was decided that a proud demise of the Chiropractic Family Physician with banner raised high was preferable to a slow death.

In the few short years that the CFP has been published it has reached chiropractic physicians throughout the country and around the world. It is the only professional journal in chiropractic with a no apology eclectic editorial policy. The message has been vigorous and sometimes abrasive. Because of this we have made enemies, but those who would restrict the broadness of our concepts we don't want as friends anyway. By far most of the comments we

(Continued on p. 10)

ZOLLINGER-ELLISON SYNDROME

by Paul Kerr, B.S., D.C.

In 1955, Zollinger and Ellison first described the occurrence of multiple gastric and duodenal ulcers in patients who had continuous stimulation for hydrochloric acid secretion. Over the last twenty-five years the clinical, roentgenographic and therapeutic aspects of the disease have changed considerably. Today it is known that Zollinger-Ellison syndrome (ZES) is characterized by gastrin-producing tumor (usually a non-beta islet tumor of the pancreas), hypersecretion of gastric acid, peptic ulcer and diarrhea.

The hypersecretion of gastrin is responsible for the clinical manifestations. Pancreatic tumors may occur as a single lesion in approximately 30% - 50% of the cases, but the majority occur as multiple lesions and are malignant in their behavior.

It is important to understand that ZES is uncommon, but not rare, and accounts for approximately 1% of peptic ulcer disease. (3) The profile on the patient is likely to be a male (60% more often), 40 - 60 years old, with persistent symptoms of peptic ulcer disease and diarrhea. The patient may give a history of being treated for peptic ulcer disease to no avail. To review briefly, the symptoms of peptic ulcer disease are dependent on where the ulcer is located. In the duodenum, the symptoms would be epigastric pain thirty minutes to four hours following meals. The pain is relieved by eating and antacids. The pain is usually aggravated by acid foods and may wake the patient up in the middle of the night, particularly if the patient eats just before going to bed. Gastric ulcers are less likely to have the pattern of pain associated with eating. The pain is usually not relieved by antacids, as in the duodenal ulcer.

The diarrhea in ZES is caused by large volumes of gastric acid secreted into the gastrointestinal tract. Diarrhea is seen in over a third of the patients.

The diagnosis of ZES is based on the correlation between historical, physical and laboratory evidence.

TABLE I

History:

Male (60%, female (40%); middle-aged (40-60 yrs.); peptic ulcer symptoms; diarrhea; history of treatment for peptic ulcer disease.

Physical:

Tenderness in epigastric area; weight loss.

Laboratory:

Elevated serum gastrin (500pg/4ml. Unresponsiveness to histamine challenge for gastric secretions. Basal acid output (BAO) of 15 mEq/hr. Barium studies to evaluate the stomach and duodenum. Endoscopy.

Since Horschowitz' discovery of the fiberoptic endoscope in 1958, the endoscopic examination has played a major role in the actual viewing of the upper G.I. tract, without the hazards of a non-flexible endoscope.

The chiropractic physician has a responsibility to evaluate such a patient. If you have a patient with peptic ulcer disease and diarrhea, the following diagnostic procedure is suggested.

TABLE II

Work-up for ZES:

1. Complete blood count (CBC) — with particular attention to white blood count (WBC) to look for leukocytosis; may indicate peptic ulcer perforation.
2. Erythrocyte sedimentation rate (ESR) — elevation may indicate ulcer perforation.
3. Fasting serum gastrin level — 500 pg/ml.
4. Upper G.I. barium study.
5. Endoscopy.

A closing note on treatment of ZES. Until recently, the treatment has been total gastrectomy. The new H²-histamine receptor antagonist drugs, such as cimetidine, offer new hope for the ZES patient. As primary care physicians, we must not forget our patients just because they have a condition which requires medical therapy. These patients need careful consultation on diet and nutritional supplementation, as well as chiropractic manipulation. Let us never forget the visceral influence we can have by adjusting the spine.

PAUL C. KERR, B.S., D.C.

Dr. Kerr received his B.S. degree in Chemistry and Physics from Bowling Green State University and D.C. from National College of Chiropractic. He is presently Chairman of the Department of Pathology at the Los Angeles College of Chiropractic.

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THE "FAT PAD SIGN"

The "displaced fat pad sign" is useful in the diagnosis of obscure fractures of the elbow. Normally there is a small accumulation of fat adjacent to the anterior surface of the distal portion of the humerus. If the joint capsule is distended by fluid this fat pad will be displaced forward and upward giving a sail appearance of fat density — radiolucent area. There is a similar fat pad along the posterior surface of the humerus but in the normal it lies largely within the olecranon fossa and is often not visible. When displaced, it has a crescent shape. The view on which to look for the "fat pad sign" is the lateral, taken with the elbow flexed 90 degrees. Any process producing synovial or hemorrhagic effusion within the elbow joint will displace the intracapsular extrasynovial fat pads. In addition to trauma, this sign may occur in any disease or condition in which there is synovitis (e.g. Rheumatoid arthritis). (Note: occasionally the fat pad can be seen in the normal and may not be seen in the emaciated individual.) Recognition of the abnormal position of the fat pad should cause the observer to search carefully for bone injury if it is not readily apparent. Two intra-articular fractures involving the elbow are of primary concern — especially since they are both easily missed and occasionally occur simultaneously. These are the fractures of the radial head and capitulum. The presenting complaints are often pain and swelling with a history of having fallen on an outstretched arm. The head of the radius impacts upon the capitulum causing cartilaginous damage as well as bony disruption. Point tenderness over the radial head suggests the diagnosis. If the fat pad sign is found, further views of the elbow — supination and pronation done carefully may demonstrate the fracture line (see figure one for a diagram of the fat pads).

SHARON A. JAEGER, D.C., D.A.C.B.R.

Dr. Jaeger is a diplomate in roentgenology. We are pleased that she has consented to lend her expertise in this field as a regular contributor to the CFP. Most of Dr. Jaeger's contributions will be directed toward soft tissue pathology, a greatly neglected area in chiropractic diagnosis.

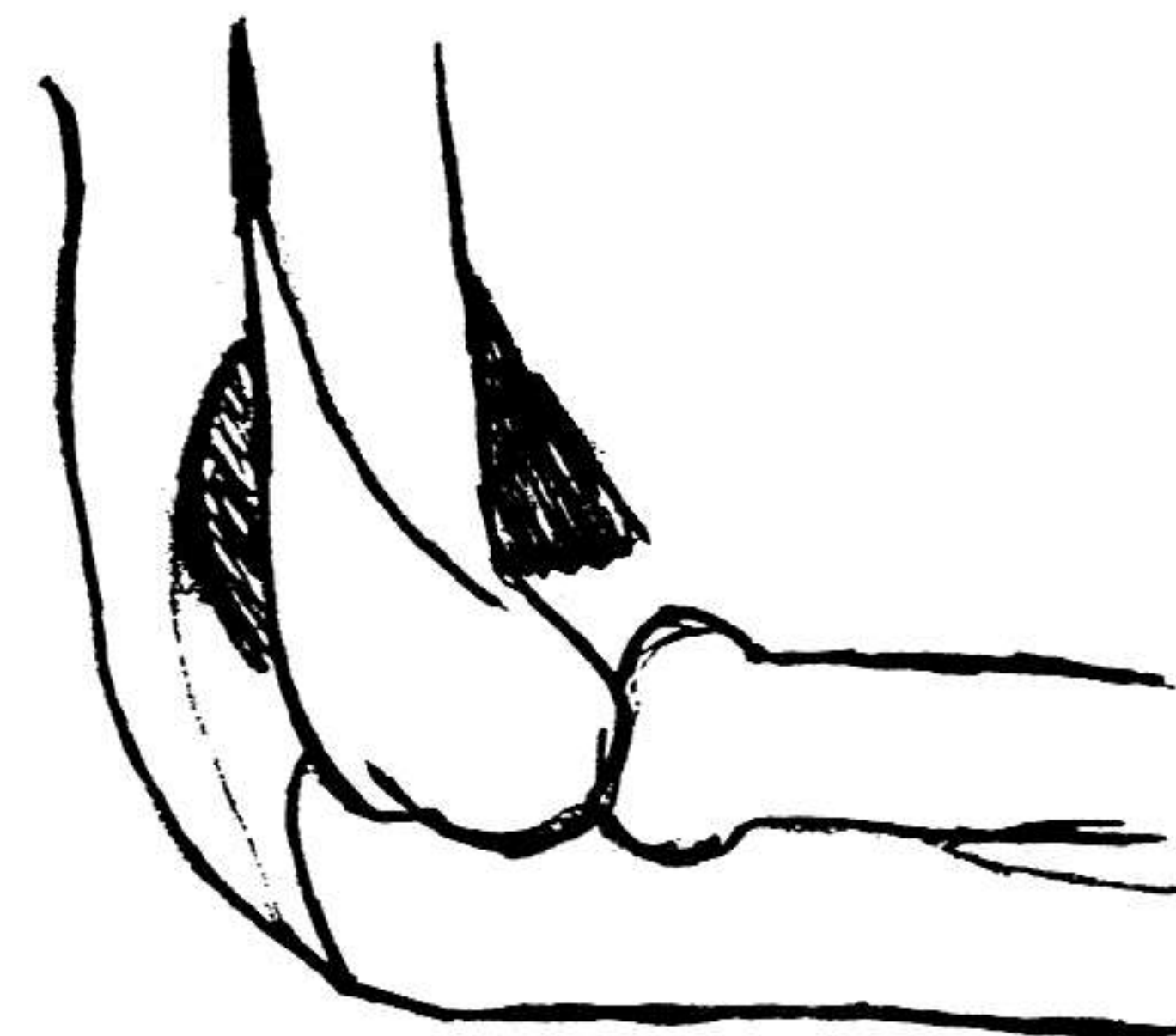


Figure 1

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EDITORIAL (continued from pg. 5)

receive are favorable. We know that the majority of well-educated men and women in our profession are interested in being primary physicians and feel that it is their duty as physicians to extend themselves morally and professionally as far as their license to practice allows. They are not afraid of the responsibility that the term "primary physician" places upon them. They welcome the challenge and are proud of their education and therapeutic and diagnostic skills. This is the majority. Then there are those who dwell in the shadow world of a pseudo religion. Their cause is simple — the destruction of those who don't agree. I have witnessed everything from the bellicose tub-thumper to the wild-eyed salivating fanatic. All had the same message — practice as I tell you to or get out.

Those against us will dance over the tombstone of this journal — *if you let us die*. The more tragic consequence however, is not the possible delight of some intellectual cretins but the demise of a definitive articulation of the concepts of progressive health care shared by so many in our profession.

What can be done? A great deal. If you are not a member of the Council on Diagnosis and Internal Disorders, then join — *now*. If you have not purchased "Dynamics of Correction of Abnormal Function" then do it — *now*, for all the money goes to help defray the cost of publication. Seems simple doesn't it? Yet how many of you will say to yourselves "By golly, I'll have to help out — maybe tomorrow." Unfortunately, if you wait for tomorrow, it won't arrive — at least not for this publication. It's up to you.

If this is the last issue — so be it. You will have spoken through your silence and lack of commitment. ☐

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WHO'S BOSS — DOCTOR OR PRACTICE?

Jay D. Kirby, B.S., M.A., D.C., Ph.D.

Before entering chiropractic, the author practiced as a consulting Psychologist and was a partner in Professional Guidance Associates. His Master's degree is in Human Behavior. He is presently the Director of Research at Vitaminerals, Inc., Glendale, California.

He is a member of the Council on Diagnosis and Internal Disorders.

Special to **THE CHIROPRACTIC PHYSICIAN**

The doctor has gotten to the point that he just doesn't enjoy practice any longer. He has a large patient load, but he is working himself into a state of utter exhaustion. After a hard day at the office, he arrives home late, falls asleep in front of the TV right after dinner, and is being hassled by his wife and family for not spending waking time with them. He has been forced to cut back on his attendance at professional meetings and seminars. He has resigned from his service club and is too tired to attend church. Gradually his areas of interest have become more and more restricted. His social life has become almost non-existent.

True, he has another doctor give him regular adjustments, and he takes the right vitamins in therapeutic dosages. He watches his weight, and he even started jogging but didn't have the energy to keep it up.

What is wrong?

An examination of his own office behavior might have given him a few clues. He is no longer controlling the practice — the practice is controlling him. He might see that a little office behavior modification could solve his problem, not impair his income, and could provide rich dividends in conserved energy, revived interest, and in adequate time for other things.

This doctor has three great faults that appear to him to be virtues. A. He is kind and concerned, so much that he cannot say "no." He spends extra time with patients when it is not really necessary. He spends a half hour or more with a detail man, when less time might have done, then finds that he has fallen behind with his patient schedule.

B. He feels that he must make all of the decisions himself. Nothing can be left to the other person. His C.A. is only an automaton who executes his orders. This all leads to fault C.

C. He does every one else's work for them, in addition to his own work. A behavioral analyst, after studying Doctor's case could make the following suggestions:

1. Eliminate the writing of long case histories. Purchase or develop a "patient questionnaire" so that the patient can fill in and check off the pertinent points in the history. Adopt or develop a "fill-in check-off" type of history.
2. Use the same type of check-off fill-in form for recording the facts necessary for writing narrative reports, and train one of the office personnel to do the "Joe job" of typing. Professionally done narratives are now available, and are real time and energy savers. Better, invest in tape recorders (with foot switches) or dictation equipment and dictate.
3. Don't personally administer physical therapy. Use a skin marking pencil, or even a blunt ball point pen or felt material, outline the area to be treated, write the strength, distance, time, etc., right on the patient's skin, and have an assistant give the actual therapy. The writing will come off with a pledget of cotton and a little alcohol.
4. Don't make telephone calls except in an emergency. Set aside a brief period of time in which you will return a call. Take a cue from attorneys, they log the beginning and ending times of all phone calls, and establish a limit. Purchase a small timer, and set it at the maximum time allowable for a call . . . 3 minutes should do it nicely.
5. Use a small "appointment time and charge" pad that slips easily into the pocket. Jot down the information, and send it to the front by the patient.
6. Let the C.A. handle the money and fill out the insurance forms — all you need do is check and sign them, but by all means, check them.
7. Delegate non-essentials such as taking vital signs, setting up rooms, developing films, updating histories (use that recorder) to someone else. A back office girl, properly trained, will be worth her weight in gold and can save time and energy as well as money.
8. Spend the first 30 minutes of the day previewing the case histories of those patients you will see that day, and make notes to yourself. Have your staff in on the briefing. You'll turn patients faster, and your staff will be coordinated.
9. See new patients in the mornings — revisits in the afternoon.
10. Group patients by their conditions, the office routine goes faster and better that way.
11. Transfer all State Aid and low pay patients to the afternoon of the deadest day of the week.
12. Schedule 15 minutes morning and 15 minutes afternoon for your "break" and let nothing short of an emergency interfere with it. Relax, mind and body. Snooze — think outside the office. Do some wool gathering. Mentally "go fishing."

13. When the schedule gets loused up (as it will), instead of trying to make up for lost time, have the front office telephone patients who have not left home, and reschedule them — "Doctor has an emergency", is always legitimate.

14. Do not — repeat, do not let patient or employee dally around after closing hours. Set firm opening, lunch and closing time, and stick with them.

Get to the office on time
Get to lunch on time
Return from lunch on time

and

Go home on time.
Be a clock watcher!!!



LAB REVIEW

Undoubtedly one of the most important diagnostic tools any physician has is found in laboratory analysis. It is not a perfect tool, but used in conjunction with other forms of diagnostic application it often leads to a viable assumption. We are often confronted with a patient's systemic stress condition and just as often neglect to use laboratory diagnostic procedures to confirm a conclusion that has been made, before we should. Below are listed a few disease processes and the laboratory tests that are suggested as the most efficacious.

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Total Protein

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Alkaline Phosphatase

Kidney Function

Creatinine
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Uric Acid
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Potassium
Sodium

Addis Count
A/G Ratio
Urine Culture
Serum Lipids
PSP
Creatinine Clearance

Thyroid Function

PBI
T3
T4 by Column
T4 (Murphy-Pattee)

Cholesterol
Free Thyroxine
Thyroxine Binding Globulin (TBG)



LETTERS TO THE EDITOR AND COUNCIL

To Doctor Nelson:

At some future time when the postgraduate classes in your work are offered I truly do hope to be able to attend. It seems that in life there is *so little time* and so many interesting things to explore! Over the years I have had a little correspondence with Dr. A. Earl Homewood, who is a most interesting man. I think that all of us are very concerned with the direction that the chiropractic profession is taking. Although I have been quite involved with the chiropractic orthopedists, I do not by any stretch of the imagination believe that the profession as a whole should take such a very limited approach. In one of his letters Dr. Homewood stated, "Your 'Wear and Tear' presentation in the February A.C.A. Journal provided considerable food for thought. Of course, your urging of the profession to return to its neurological basis struck a most responsive chord. Losing sight of the reason for adjusting vertebral segments is tending to lead the profession into an ancillary position from which it will be most difficult, if not impossible, to escape." How true!

(Continued on pg. 16)

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LETTERS TO THE EDITOR (Continued from pg. 15)

Recent issues of the *Chiropractic Physician* have had some articles by Dr. Homewood. It seems that the ACA simply has become so involved with Washington, D.C. and their concern for the colleges that there is a very low priority given to the various Councils. They are simply left to sink or swim pretty much on their own. This is really sad. I think that this attitude, though perhaps not publicly expressed is sensed by many within the profession. There is a realization that there is more to chiropractic than orthopedics. And yet, so many in influential positions within the profession are staunch orthopedists that a real problem does exist. It is obvious that Dr. Homewood senses this and is therefore contributing his thoughts to the profession thru the pages of the *Chiropractic Physician*. Keep up the good work.

Sincerely yours,
Andrew R. Jessen, D.C.
Salinas, California

Dear Dr. Tyler:

My article in the March issue of the C.F.P. elicited several inquiries re to certification of Chiropractic Specialists.

Response to the inquiries — In the 1940s the Southern California College of Chiropractic expanded a graduate school program to meet graduate study requirements leading to specialty certification.

The various Specialties i.e. Cardiology, EENT, G.P., Family Prac., Internists, OB Gyn & Ped, Orthopaedics, Proctology, Psychiatry, Radionic Research etc. paralleled their requirements to those certifying programs in the specialties of the Traditional Profession. Many of these Certified Specialists (members of the Traditional Profession) were on the Graduate School Faculty of S.C.C.C.

As the program developed each of the Specialty Societies elected a representative to serve as a delegate in the House of Delegates of the Chiropractic Educational Specialty Societies.

A membership in the CCA and the NCA was required for Specialty Society membership.

There was no grandfathering in any of the Certified Members. When the graduate course of study approved by the particular Specialty Society was met, those members who qualified as Candidates for certification were examined by a Certifying Board who had as its Chairman a Certified Member in that Specialty in the Traditional Profession. Subsequent Certifying Boards were then made up of Certified Members from the original group of Certified Chiropractic Specialists.

The N.C.A. had Councils for the various Specialties. OB Gyn & Ped was one of the Councils that was, along with others, to move from a California Certification to a National Certification. This was during the period of time when the reorganization of the profession was taking place and the present A.C.A. came into being supplanting the N.C.A.

Due to political, legislative, internecine as well as external pressure many of the Specialty Societies were in an attenuated state while efforts were concentrated on accreditation committees and efforts to upgrade the schools. Graduate School Programs as well as Specialty Societies were held in abeyance.

A resurgence of interest in Specialty Certification seems to be mounting and, of course, it should be reestablished under the auspices of the A.C.A.

Dr. L.E. Montenegro
Torrance, California

(Continued on pg. 25)

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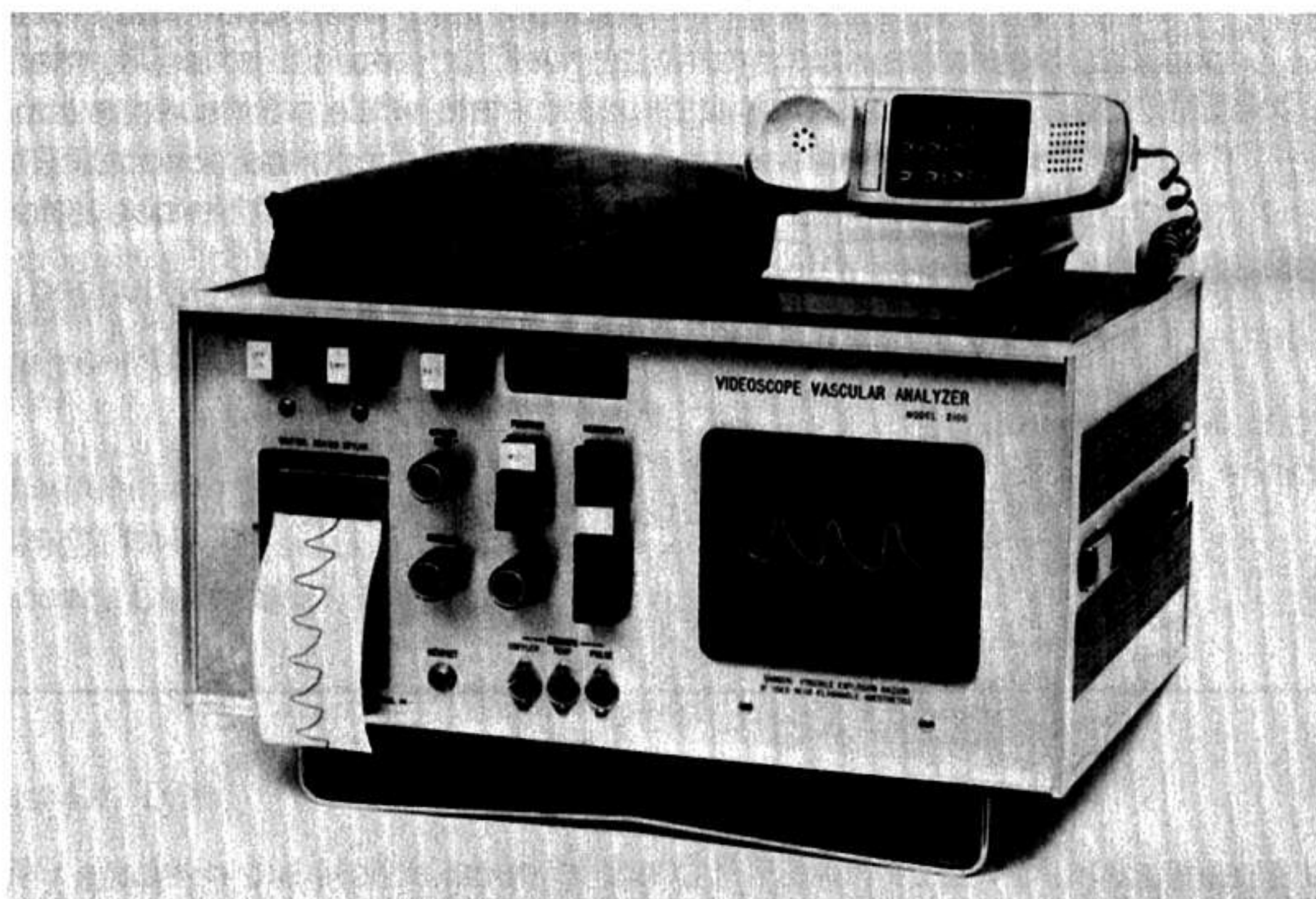
Phenylalanine has been called the appetite-reducing amino acid because it is turned into norepinephrin and dopamin which are excitory transmitters that will keep you alert and awake, eliminate depression, and reduce hunger. Phenylalanine also causes the release of a hormone called CCK which signals your appetite control center that you are full. According to Durk Pearson, a specialist in life science with a physics degree from M.I.T., "If you take a rat and inject CCK into it, that rat will starve itself to death next to a bowl of food, because the hormone tells it, 'Hey, I'm not hungry. I'm full. I don't need to eat anymore.' It's not a matter of willpower at all. Phenylalanine releases CCK and you simply don't feel like eating so much."

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BOOK REVIEW

"CHIROPRACTIC AND PEDIATRICS"

by Dennis L. Medsker, D.C.

& Paula A. Medsker, D.C.

There is a paucity of information about pediatrics and chiropractic. It is therefore welcome when a text arrives that has the title "Chiropractic and Pediatrics." Seems simple, doesn't it? I thought so when I purchased the volume at the college bookstore. While all the ingredients were there, I felt somewhat uninformed after I finished reading it. Maybe I expected too much or maybe there just isn't that much to say about chiropractic and adjustments.

The book consists of 113 pages divided into four sections and 12 chapters. Upon reading the table of contents it would make you think that all you might want to know on the subject was there. Not so. One of the problems may be that the authors seemed a bit confused about who they were writing the book for. At one moment it seemed aimed at the layman and then suddenly it would appear directed to the chiropractor. I got the feeling that their subject was a skeleton and they were trying their best to flesh it out with sometimes meaningless rhetoric and photos.

It wasn't all bad. Nothing is. *Almost* nothing is. Some of the technics were interesting and of value. It would have seemed appropriate, however, if there had been a section on conservative care for emergency situations, and possibly a section on herbal and homeopathic remedies. It is wrong to extend health care of any kind based upon a single concept. This is a failing of the profession and unfair to the public.

The volume sells for \$17.00 and may be purchased from most chiropractic college bookstores or from Chiropractic Educational Services, 534 Union Arcade, Davenport, Iowa — 52801. With all its faults, there is enough in it to be worth the purchase.

Richard H. Tyler, D.C.

"EVERYTHING YOU SHOULD KNOW ABOUT CHIROPRACTIC"

by Chester A. Wilk, D.C., P.C.

Here is a small 74-page volume that isn't at all confused about the audience it's trying to reach. The book is pure propaganda for the profession. It is told succinctly and in an easily read manner which makes it excellent for the patient who is curious and in a hurry. Of the 14 chapters listed, the one on the connection between adjustive procedures and the functional integrity of the viscera was most satisfying to me. We are a complete health service. We are able to influence directly or indirectly virtually all systems of the body. We aren't a panacea, but it is wrong to dismiss such a viable form of treatment as chiropractic in favor of radical procedures. If not a primary form of care in every case, we can and should always be used at least synergistically.

The only sad note in all this is that we still find it so necessary to continually educate the public. However, until we have a Marcus Welby or Rex Morgan to give us free boosts it is up to the profession to do the job, and Chester Wilk, as usual, does his job well.

Each book costs \$2.25 and may be purchased for less in bulk orders from Chester A. Wilk, D.C., P.C., 5130 West Belmont Ave., Chicago, Ill. — 60641.

Richard H. Tyler, D.C.

CLINICAL INVESTIGATIONS of the “DYNAMICS OF CORRECTION OF ABNORMAL FUNCTION”

Ralph J. Martin, D.C.

The publication in 1960 of Dr. T. J. Bennett's book "A New Clinical Approach to the Correction of Abnormal Function" gave promise that many windows had been opened with hopeful prospects that fresh new breezes would be blowing through the drug-filled, stagnant ball of therapeutics. This writer had been attending Dr. Bennett's classes for seven years at the time his book was published.

From the beginning I witnessed patients' reactions to his clinical teaching, that were both amazing and convincing, and I began using his work in my own practice with ever-increasing success and satisfaction. The scope of his work was so vast and response of patients so dependable it was to me like a whole new world which made the old accepted concepts so incomplete and obsolete I was overcome with enthusiasm as I introduced my patients to its wonders. I was enormously pleased with how quickly patients not only responded but were deeply impressed with its simple but dependable capacity to quickly relieve pain and restore the body to normal function.

In 1957 I began teaching this work as part of senior classes final course in technic for about four years. From this experience I concluded that undergraduates were not at that time ready for advanced clinical studies and ceased teaching in the college (Los Angeles College of Chiropractic).

After a period of several years of further testing and improving the application of the basic concepts, I began holding graduate level classes, enrolling only practicing doctors as Dr. Bennett had done. Several courses of classes were given in the Southern California area and in 1969 I held a class in Des Moines, Iowa which was organized by that very fine gentleman Arthur M. Schierholtz, D.C., who was secretary for The Foundation for Chiropractic Education on research. The Des Moines class went well and in 1970 I held classes in Minneapolis, Northwestern College of Chiropractic, Portland, Oregon, Western States College of Chiropractic, and Los Angeles College of Chiropractic in Los Angeles. I held a class in each area, the first weekend in one area, the second

weekend in a second area, and the third weekend in a third area. Each class consisted of 6 hours on Saturday and six hours on Sunday, so I had only one free weekend each month from January through May of 1970, as each group was given a total of 60 hours of classes.

Classes consisted of lectures and demonstrations and the doctors were encouraged to bring in problem cases as much as possible. There was not as much clinical material as we would have liked as many of the doctors came from long distances and surrounding states. I charged only a flat fee to cover essential expenses and encouraged the colleges to participate in the program so that all profits went either directly to the colleges, or to F.C.E.R. Due to the fact that some members of the F.C.E.R. Board of Trustees, who posed as broad-minded, but really had no concept of what we were teaching, objected to further sponsorship of the classes on grounds of prejudice and archaic concepts of chiropractic philosophy and practice.

The doctors in the classes were most attentive and appreciative and very many found the work a great boon to their practices. I myself was 66 years of age and found the pace of teaching a severe drain on my energy, so have not engaged in further intensive teaching schedules. I taught two hour sessions once a month from 1972 to 1975 in the L.A.C.C. Council on Diagnosis and Internal Disorders leading to examination as "Qualified Internists" and also in a later class in 1979 and 1980 leading to "Qualified Internists."

At present I am practicing only 5 mornings a week and trying to complete a new book for publication. As one gets older it becomes necessary to spend more time recording what one has learned, rather than engaging too heavily in physical clinical activities that drain the receding margins of energy. In recording the conclusions of well over 4 decades of practice and the results of our efforts, it is sincerely hoped that we may awaken a new generation of clinical seekers who will carry on the never-ending quest for better human health.

NEURAL CONTROL OF IMMUNITY

by Edward E. Cremata, Senior Intern
Palmer College of Chiropractic-West

For years it has been known that the nervous system controls and coordinates all the functions of the body, including that of the pituitary gland which masters the endocrine system. With this in mind, it comes as no surprise that recent studies document that the immune system is also controlled by the nervous system. Since most disease states, including cancer, have been shown to be due to a decreased immune function, it is postulated that neural intervention of immune control, whether physio, chemical, or physical is the primary cause of lowered resistance and consequently disease. Clinical evidence supporting this hypothesis has been claimed by many health care practitioners. Chiropractors, who reduce physical nerve interference by eliminating subluxations (segmental spinal stenosis), are one group who utilize this

neuro-immune relationship in the prevention and treatment of disease. Until recently, the mechanism of this relationship was unknown, and therefore this important concept had been ignored. Abundant psychological research has been conducted to explain how altered mental function (i.e., stress, anxiety) acts as an immunosuppressant and chemical introduction of neural effectors have been shown to act as immunosuppressants. These recent studies may help to explain what Hippocrates meant when he said: "For the cause of disease, look to the spine."

Lesions of the sympathetic nervous system have been shown to increase the incidence,^{1*2*3} induction,⁴ and take and growth⁵ of tumors. In neurally intact rats which were infected with a known carcinogen, only 1/30 developed a tumor. When sympathectomized rats were injected with the same carcinogen, 24/38 developed tumors.⁵ These results confirm that sympathetic block enhances tumor implantation. It may be inferred that other agents, physical, psychic, or chemical, could equally paralyze the sympathetic system, either at the level of the sympathetic chain, the ganglia, the nerve terminals, or the neuro-cellular junctions. Such paralyzes could promote the evolution of spontaneous, induced, or transplanted tumor. Cancer may have a two-stage genesis. The most probable initiating agent is sympathetic nerve interference followed by any of the multitude of known "carcinogens" which may actually be merely promoting agents. A promoting agent cannot have its effect without some type of catalyst. The high incidence of lung cancer among cigarette smokers may illustrate this two-stage process. The initiating agent may be nicotine, which specifically blocks the sympathetic ganglia, whereas the promoting agent may be the benzpyrene present in tobacco tar. The inhalation of cigarette smoke is thought to depress the local immunity in the respiratory tract.⁷ Without this immune suppression, it is unlikely that benzpyrene, or any other carcinogen, would alone cause cancer. Other studies have shown that a combination of drugs, including L-5 hydroxytryptophan (a serotonin precursor), dopamine, haloperidol, and phentolamine (an alpha adrenergic blocking agent), when administered a few days before and after immunization, led to specific and long-lasting unresponsiveness to the specific antigens administered.⁸

Age seems to play an important role in immunity. It has been known for some time that in human beings humoral immunity is not fully developed at birth and does not become fully potentiated until approximately 1-2 years of age.⁹ There seems to be relatively little information about cellular immunity in newborns. Its existence is verified by the presence of delayed hypersensitivity reactions. It is interesting to note that the nervous system is also not fully developed at birth which correlates with the lack of immunologic maturity. The prevalence of malignancy increases in an older population and many people feel that disordered immunity contributes to the development of malignancies. There has also been more direct evidence. A study of 52 persons over age 80 showed significant correlations between diminished delayed-type hypersensitivity and greater mortality.¹⁰ These data lend support to the notion that immunosuppression of the magnitude that neural interference can induce, may add to an organism's susceptibility to disease and death.

By directly stimulating the brain, several investigators have produced alterations in the immune response. Lesions in the dorsal hypothalamus of rabbits have been shown to suppress both humoral and cellular immunity.¹¹ The same Russian authors have described the effect of mesencephalic stimulation in enhancing antibody responses.¹² Fessel and Forsyth demonstrated a doubling of gamma globulin levels by electrical stimulation of the lateral hypothalamus in rats.¹³ Bilateral hypothalamic lesions in guinea pigs have been shown to be effective against lethal anaphylaxis.^{14*15}

In further studies it was found that anterior but not posterior lesions protect against anaphylaxis.¹⁶ In addition to demonstrating the protective effect of anterior hypothalamic lesions against anaphylaxis, Macris and his colleagues found that they lowered antibody titers and decreased cutaneous delayed hypersensitivity by this technique.¹⁷ The direct effect of the hypothalamus on immunity exemplifies the diversity of stimuli which can affect immunity. The hypothalamus receives stimuli from all other parts of the brain and appears to be the primary controller of the automatic nervous system.¹⁸ It is now becoming clear how nerve interference, whether from psychological stimuli from the cerebral cortex, physical autonomic interference from a subluxation of the spine, or chemical intervention, can have such profound effects on homeostasis.

Clearly the autonomic nervous system is exquisitely sensitive to information from all parts of the nervous system and may affect many aspects of the immune response. Adrenergic nerve endings can be found in the spleen and in the thymus and may have a more direct relationship on immunologic reactivity. In fact, a recent study reports a suppression in a primary immune response (in both antibody titer and number of plaque-forming cells) after chemical sympathectomy in mice by the use of 6-hydroxydopamine.¹⁹ There is also the possibility, since lymphocytes have B-adrenergic receptors, that sympathetic release of adrenalin can modify cellular immunity. A recent report provides evidence that chronic B-adrenergic stimulation over a period of several days decreases the number of B-adrenergic receptor sites on polymorphonuclear leukocytes.²⁰ Further studies which show an increased rate of neuronal firing in the hypothalamus immediately after antigen antibody interaction and prior to any change in thyroid or corticosteroid hormone, are also suggestive of a direct link between an immune reaction and the central nervous system.²¹ This is consistent with previous studies hypothesizing that the immune system receives the necessary information to produce a specific antibody for each antigen by the nature of the antigen's electrical field. This type of information can only be transmitted via the nervous system.

These studies really prove nothing new. This would seem to indicate some question about the accuracy of the specific etiology basis of disease. In the specific case of cancer, enough evidence has been presented above to conclude that to fight "carcinogens" is to merely fight promoting agents rather than to attack the cause or initiating factor of cancer. It is likely, and sufficiently documentable, that most disease has the same etiology — lowered resistance. Since the immune response is initiated by the nervous system,⁶ this appears to be a likely place to look for the cause of disease. Only when the immune

system is overwhelmed does the introduction of pharmacologic agents seem logical. Many great minds have addressed themselves to this concept. Thomas Edison said, "The doctor of the future will give no medicine, but will interest his patients in the cause and prevention of disease." When the great Pasteur, one of the strongest supporters of the specific etiology theory, lay in terminal illness in 1895, he reflected once again on his long-scientific disagreement with Claude Bernard. Pasteur's dying words were, "Bernard was right, the microbe is nothing, the terrain is everything." 1895 was also the year that D.D. Palmer, the founder of chiropractic, stated, "... the cause of disease is any variation of tone — nerves too tense or too slack."²² The evidence is overwhelming. We can no longer say to a patient we have tried everything, until we have tried chiropractic. In combating disease it appears that nature needs no help — just no interference.

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LETTERS TO THE EDITOR (Continued from pg. 17)

Thank you kindly for sending me a copy of the article you have submitted to the Chiropractic Family Physician, "An Hypothesis".

Bill, I too share your concern for the present 'status' of the profession. There does need to be progress. But, as you so succinctly put it in your article, "established institutions resist change with vigor". How true that is!

I will refrain from any comment on your article at this time, because I really do not know enough about your work to be qualified to comment. As time passes I do plan to become better acquainted with your work.

Bill, there seems to be a feature in chiropractic that I did not see in engineering. In engineering, the colleges taught the basics and fundamentals. In chiropractic this same process occurs, however, after entering practice there seems to be an unusual attachment between the profession and the colleges. *Any growth of new ideas that is going to take place rightly should come from the profession, not the colleges.* The automobile and the airplane were not invented in a university. *As a rule, all growth and progress takes place outside the confines of the academic institutions,* but with the use of many of the tools of learning that were learned inside the academic institutions. For the colleges to have, and to transmit to the profession, the feeling that the profession is somehow beholden to them is ridiculous.

There should be within the profession, a forum for the exchange of new ideas and techniques. Ideally this would be provided by the professional associations. However, despite what may be said, that the ACA and the CCA are primarily political entities can hardly be denied. Indeed, they do serve a purpose. However that purpose is primarily political and secondarily to support the colleges. *The colleges have a grossly unbalanced influence on the professional associations.* And as a result the associations are made to feel an unusual and abnormal obligation toward the colleges. *This abnormal relationship between the colleges and the professional associations has served to make the general chiropractor, (although through his dues he is paying the freight so to speak), feel like an outsider and generally left out of the mainstream of activity.* This I be-

lieve is one of the primary reasons for the continual membership problems the profession has had. As currently constructed the ACA and the CCA exist primarily for the benefit of the colleges, not for the profession. The FCER of the ACA is a great big E and a very little r.

I do believe that there are some indications of change however. Dr. Ted Schrader over in San Lorenzo is quite active with the ACA Council on Technic, and they are really endeavoring to get more Doctors active and involved with their group. Working for changes within the professional associations, although at times very frustrating because of the inertia of any larger organization, is really the way to go. There are way too many 'outside' technic peddlars that all eventually fall by the wayside.

Again, thank you for the consideration.

Keep up your good work with the *Chiropractic Family Physician*. It is being read, and I have heard some favorable comments about the articles it contains.

Respectfully yours,

Andrew R. Jessen, D.C.
Salinas, California

□

EXCERPTS FROM DR. NELSON'S REPORT

The minutes of the last Board of Governors (ACA) meeting show a motion passed, promoted by CCE, that the council diplomate programs shall be reversed. All programs will be sanctioned by CCE. I have written a letter to my governor and delegate to the effect that, by not hearing the other side, they violated courtesy and judicial procedure. I am not sure ACA cares; CCE is in the driver's seat. The CCE claim appears valid on the surface. The council objectives must be within the capabilities of CCE to teach. The real question is, "Who should determine the level of postgraduate education; the field or the colleges?" We feel the man in the field knows best the needs of the field. If we permit the colleges to set the standard of any council progress, it will be as far as the colleges feel is adequate and this does not imply much progress. We can see the advantage of mutual cooperation between the council and CCE in setting up curricula but not absolute dictatorship by CCE as indicated in the motion. We are striving to retain some autonomy.

PROPOSED EDUCATIONAL TAPES FOR IN-DEPTH INTERNIST TRAINING:

It is claimed that 3 hours by tape is equivalent to 6 hours in the classroom. When the first three tapes are returned to LACC, the next three are mailed. The fee structure allows the college reimbursement for the mailing and record keeping that should keep them happy, even without the classroom. The colleges want revenue and I believe this will provide the same or more.

To start, I propose the NVD reflex system. This will give our people an opportunity to handle functional internal disorders that they tend to shy away from because of lack of diagnostic skill or a feeling of incompetence. With this under their belts they'll certainly feel like physicians.

We are pretty much in agreement that much of our problems with CCE is our desire to go beyond the spine. NVD provides an opportunity to expand the armamentarium and still stay within the limits of chiropractic as defined by the colleges. Of course, no matter what is taught, no claim could be made that the hours will mean anything. Only after we have CCE approval could the college apply the hours to the internist program. At least we'd be doing something for our members.

Editorial note: This summarizes a dozen years of frustration by this Council with CCE and some of the colleges. We propose to implement the entire nervous system toward the restoration of normal functions and health. Chiropractors cannot expect to serve as family physicians as long as we adhere and promulgate the dogma of limiting our services to spinal adjusting. Adjustments are important and contribute much to the total of health services but there is much more to the nervous system than the spinal column and we are utilizing its every facet in neurovascular dynamics (NVD) and we are therefore able to practice as internists and family physicians. Patients respond to it with amazing rapport and every doctor who has the ambition to practice as a family physician should learn all about it through books, classes and/or tapes sponsored by this Council.

If we submit a Syllabus to CCE which deletes 'Reflex Systems' (including NVD) and stick to the spinal adjustment only, then CCE would give their approval and we could call those who complete the courses 'Internists' with their blessing. But this would be a farce for they could not provide services for a multitude of internal disorders any more than any other chiropractor who had not taken the courses.

Does this constitute the political mechanism for the protection and perpetuation of mediocrity?

R.J.M.

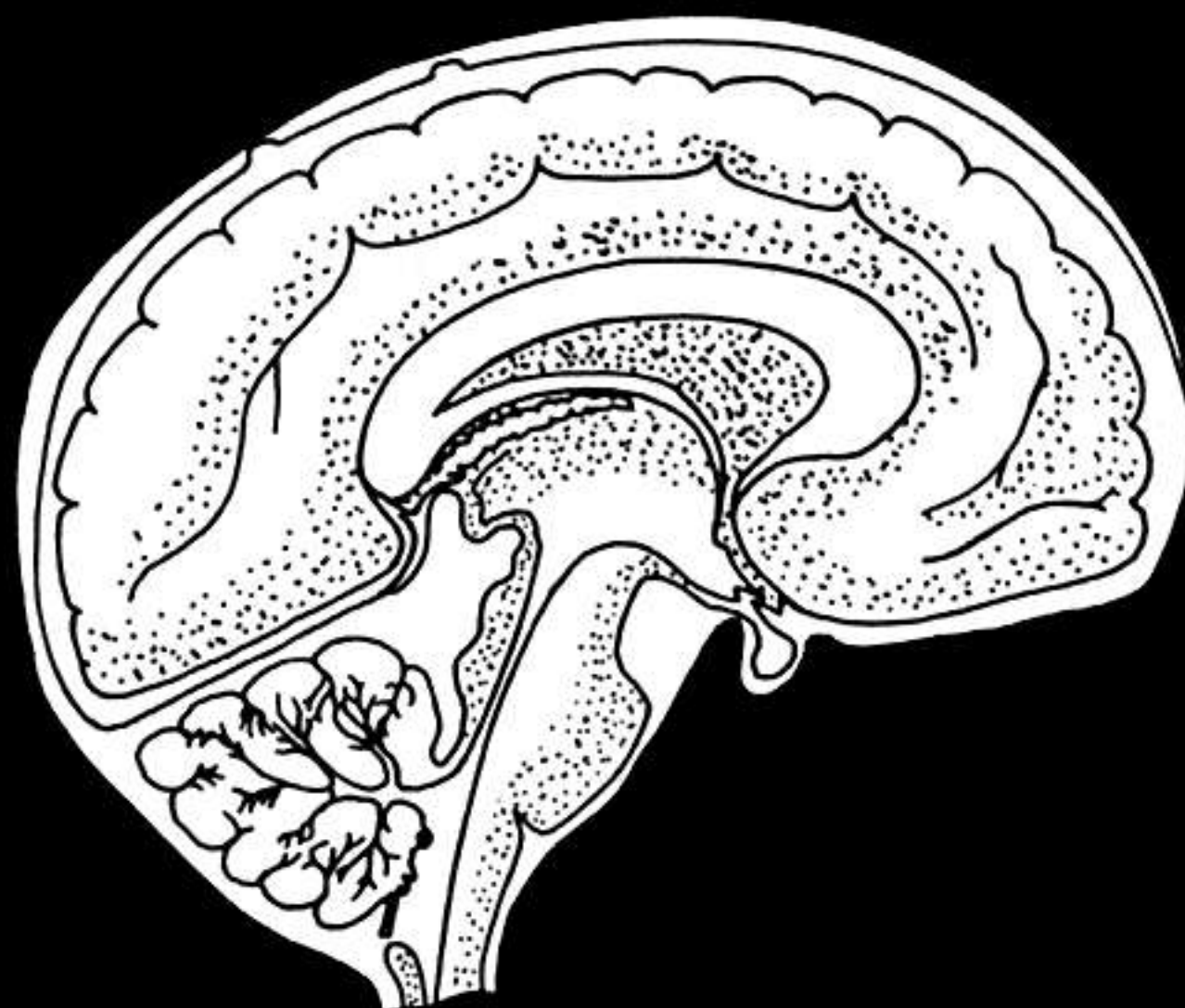
TO THOSE CONCERNED:

I am writing this letter because I am concerned about the educational progression of my profession. The following thoughts come to mind.

What is our profession doing scientifically to better itself?

Chiropractic calls itself a science, yet how many practitioners are cognizant of the "Scientific Method"? Our schools teach the basic sciences, but lend no guidance to the future practitioner as to how to apply the therapeutic efficacy of his training in a scientific manner.

In my opinion, Chiropractic clinicians are infamous for their inability to recognize and control the multiplicity of variables involved in their treatment of the



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patient. In other words, they are not practicing a science!

I would like to see the schools teaching the students about the Scientific Method — Where Chiropractic treatment is the independent variable, the response of the patient is the dependent variable, and there is an educated attempt to control the extraneous variables.

The overwhelming majority of practitioners clinical work invites neither replication nor examination. Undoubtedly many patients recover when treated by *any* practitioner, or *no* practitioner, but is there any evidence that their recovery is due to the treatment as opposed to the healing powers of the body alone, or some other therapeutic agent? Chiropractors automatically take credit for these cures without the slightest qualms about these issues. Nor do they have a proclivity for remembering and recording failures.

Science is the accumulation of observable data, that conforms to the requirements of objectivity and reproducibility. Chiropractors study the basic sciences, but there are only a paucity of practicing Chiropractors who are qualified in addressing Chiropractic as a science.

Concerned,
 Chris Wilkerson, D.C.
 Manhattan Beach, California



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THE CHIROPRACTIC FAMILY PHYSICIAN

JULY, 1981

VOL. 3, NO. 5



SHARON A. JAEGER, D.C., D.A.C.B.R.

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TRIBUTE

SHARON A. JAEGER, D.C., D.A.C.B.R.

The eyes perceive and then transmit their images to the cerebrum for interpretation. There, in these mysterious convolutions holding and recording so many memories and thoughts, is conjured up the expertise traced upon the cortical centers of the brain through education. The professions have devised learning and testing procedures so that they may maintain an educational and intellectual elite to draw upon. In the chiropractic profession we have several specialty boards. Probably the oldest and most prestigious is the board on Roentgenology. In its many years of existence only a handful have achieved a diplomate status. Of that handful, only two women hold the title. Sharon Jaeger is a diplomate.

I firmly believe that a chiropractic roentgenologist is the finest professional in the field of radiology. I'm not saying this in a professionally chauvinistic sense. After years of reading reports from our medical counterparts, I feel I may say with some measure of accuracy that the dimensions of the chiropractic roentgenologist's education are more complete than any other in the healing arts.

Dr. Jaeger attended Western Michigan University and graduated from the National College of Chiropractic in 1976 with B.S. and D.C. degrees. Teaching seemed to come naturally to her and since her graduation she has taught at the National College, Los Angeles College of Chiropractic and Cleveland College of Chiropractic — Los Angeles. Until recently, Dr. Jaeger was the Chairman of the Department of Roentgenology at the latter institution.

While still in undergraduate work Dr. Jaeger's academic skills were recognized when she was selected for inclusion in Who's Who in American Colleges and Universities, received the prestigious Joseph Janse Senior Award and was chosen the Outstanding Woman Graduate. She was also the Illinois Delegate to the Outstanding Young Women of America Conference.

With all the obligations Dr. Jaeger has imposed upon herself, she still finds time to practice her specialty at two separate locations in Southern California and to write professional papers in a number of journals.

We are pleased to honor this fine chiropractic physician and we, in turn, are honored by being the recipient of her contributions to this publication. ☐

The journal will hereafter be sent outside the United States to members of the council and to subscribers only.

EDITORIAL

"A Crisis Revisited"

by Richard H. Tyler, D.C.

There is a trend in our profession that I alluded to some time ago. I gave it a cursory swipe as one would an insect buzzing about one's head. Unfortunately that "insect" has been transformed into a vulture. It seems to wait for councils to die so that what is left may be absorbed by its voracious appetite.

For years, our biggest "interprofessional subluxation" was the straights. They are still with us, but I feel that the more rational people listen to their rantings, the more they will tend to self-destruct. The other danger that appears to be growing at an alarming rate is the trend within the ACA to think of the chiropractor as almost strictly an orthopedic specialist. There are some who would have us become the conservative appendage of the orthopedic surgeon. The idea, of course, is that it's "safe" to be a conservative specialist. Don't diagnose — don't take the chance of being wrong. Just play it safe.

Well, while we're praying with the straights and playing it safe with the orthopedists, other members of the healing arts are stealing our profession. An article in a recent edition of the Journal of the American Osteopathic Association is a good example. The paper was by a dentist on the association of malocclusion of the mandible (TMJ syndrome) with cardiac distress. The hypothesis was that the malocclusion resulted in structural compensations in the spine with the resulting neurovascular stress upon segments indigenous to the heart. Muscle testing through Applied Kinesiological procedures was used to corroborate the findings. Not a single reference listed at the end of the article was from a chiropractor. All sources noted were from medical or osteopathic papers. While we're being robbed of the very things we were so instrumental in developing, the orthopedists are hoping to restrict all of us to strict musculoskeletal problems under the premise that this is what we are most known for and do best — so let's just do that and nothing more.

It seems strangely paradoxical that as the healing arts turn increasingly to natural alternatives — as they increase the scope of their therapy — we have powerful members of the profession who continually try to have everyone practice their restricted way.

An argument for restriction where visceral function is concerned is that we really can't prove the value of the structural/functional linkage. Maybe — but that doesn't seem to bother the osteopathic profession. Just read their school catalogues and their textbooks. They state continually and without reservation their adherence to the concept that altered structure is a primary cause of altered organic function. In the meantime we, a profession historically based upon the primacy of the structural/functional relationship, stand timidly in a therapeutic corner watching our very birthright being taken away from us with the hope that everyone else will just leave us alone after they've finished feasting on our philosophical cadaver.

We are also one of the few schools in the healing arts that has developed programs dealing with nutrition, yet a prominent chiropractic orthopedist told me that he would use nutritional therapy only as it applied to orthopedic problems. Don't misunderstand me — I love the orthopedists. In fact, I completed the graduate course in the discipline and found it a major factor in my growth as a physician. My argument, however, is the same as it is with the straights — leave me alone. Stop trying to govern the way I think and practice just because you like the way you practice better. As long as I am qualified through education and am within the legal structure of my license, what business is it how I wish to practice? Good for you if you feel you can best serve your patients by adjusting just the big toe. I would no more tell you how to practice than I would tell you how or what to worship.

Let's all stop defining ourselves into oblivion. Do what you wish, but leave me alone. As long as I break no laws it's none of your business how I practice. I'm a chiropractic family physician. Only you know what you are. ☐

A NOTE FROM THE CHIROPRACTIC FAMILY PHYSICIAN

Thank you. Like physicians on an emergency call, many of you gave The Chiropractic Family Physician "wallet to publication" resuscitation. As a result, we have the issue you're now reading. This doesn't mean that we're out of the woods, however. We will survive from issue to issue only with the continued support of the profession. With this in mind let me appeal to you to enlist the support of your colleagues. Those who might share the same desire to keep our profession viable and responsive to the needs of our patients should be asked to join the council. They should also subscribe to CFP at ten dollars a year. Beginning in 1982, the subscription rate will be fifteen dollars, so now is the time to subscribe.

There's no hand-wringing or whimpering with this appeal. If you want the CFP to continue, it's up to you. If not, we'll close shop and go on to other things. I have a feeling, however, that CFP will not only survive — it will get bigger and better until it will become one of the largest and most important publications in the profession. Why? Because what we're doing is right. ☐

ERROR IN DATING

An unintentional error at the printer's placed the month of June on the cover of the last issue when it should have read May, to keep the issues in proper sequence. We are back on schedule with this issue and regret any confusion this mistake may have caused. ☐

PORTAL OF ENTRY PHYSICIAN — OR ISOLATED TECHNICIAN?

by Henry Adam Baker

The Doctor of Chiropractic is, and should be, in many instances, a portal of entry physician — the person to whom the patient first turns when illness or discomfort occurs. In many cases, the D.C. is the *only* practitioner the patient is currently seeing, and will not seek the services of another practitioner unless referred by the chiropractor.

The portal of entry, or primary physician, regardless of his discipline, must be able to recognize and to classify abnormalities in order to direct the patient to services that are recuperative, or in cases, life saving. In order to recognize and classify these conditions, a case history must be taken, a general (and in some cases a more specific) examination must be made. Based upon the findings within the case history and the examination, a diagnosis is made. Diagnosis loosely translated from the Greek, means "deciding." (It is derived from "dia" = across and gnosis = knowledge.)

There are various forms of diagnosis.

The simplest is a Presumptive Diagnosis — an educated guess.

Then there is a Working Diagnosis — enough knowledge is obtained to establish a basis for control of the case, be it within the scope of practice of the chiropractor, or a referral to another specialist.

Laboratory diagnosis involves the use and interpretation of tests on blood, urine, feces and body exudates and the use of x-ray.

To forbid the doctor of chiropractic, or any health purveyor or practitioner, the right to diagnose would not only be acting in disservice to the practitioner, but to actually place the patient in gross danger. It would be tantamount to sending a member of a rescue team to find someone, but depriving him of a searchlight or binoculars. It would be equivalent to asking the contractor to build a house, but depriving him of blueprints or estimates. In many cases, the courts have held that without a diagnosis, no practitioner should treat.

To *restrict* diagnosis, by forbidding the use of specific procedures is equally foolish and equally dangerous — leaving the practitioner only the benefit of guesswork. It would be like asking an electrician to find and repair a short, but forbidding the use of a test meter.

There are hundreds of patients alive and functioning today, because the chiropractor discovered (by diagnosis) a potentially death-dealing condition, referred the patient to the specialist who could treat the condition, and saved the patient's life. Patients generally are not trained to select a proper specialist, they must depend upon the primary physician, and many times, time is of the essence.

Hundreds of examples may be cited, among them the following:

1. The complaint was of a severe and intractable headache. Findings on routine physical examination were negligible. An X-ray skull series was taken. An unusual appearance was noted. The films were referred to a radiologist for reading, and the patient went to a neurologist for an electroencephalogram:
 - (a) Presumptive diagnosis by chiropractor — intracranial abnormality.
 - (b) Working diagnosis by radiologist — probably intracranial tumor.
 - (c) Firm diagnosis by radiologist — intracranial tumor.
2. Patient presented with a "pain in the neck, and a sore throat."
 - (a) Chiropractor examined during initial visit:
 1. X-ray and ROM of cervical spine — no findings.
 2. Examination of throat with throat swab to lab = throat clear.
 3. Blood pressure severely elevated, and "nicking" of arteries within the eye (ophthalmoscopy).
 4. Referred patient to cardiologist.

Diagnosis: Advanced arterial disease with hypertension, and possibility of impending stroke. Stroke averted and blood pressure reduced by cardiologist. Chiropractor remained primary physician.
3. Persistent Vertigo. Mild elevation of blood pressure. Pitting edema (swelling) of ankles. Lab results identified a kidney problem, (glomerulonephritis). Patient referred to internist, who instituted treatment.
4. Slight nausea, and inclination to vomiting, especially when any pressure, even slight, applied to front of throat. One lobe of thyroid slightly enlarged, discovered by chiropractor by digital examination. Laboratory examination indicated hypothyroidism. Referred to endocrinologist who ordered a thyroid scan. Hypothyroid confirmed, treatment instituted.

5. Male, 50; complained of constant low backache. X-ray lumbar series non-revealing. Prostate examination (by chiropractor) revealed enlarged prostate, of a rough, walnut shell consistency. The case was referred to a proctologist. Diagnosis — prostatic cancer. Treatment — surgical removal of prostate.

This fortunate case was caught before the cancer metastasized, and the life of the patient was probably saved. The patient would never have thought to consult a proctologist. He went to a chiropractor, because he had a backache.

Treatment of a patient cannot — must not — be instituted by any practitioner predicated on guesswork, or worse, adherence to an antiquated, long discarded, nonscientific theory or philosophy. One would be horrified to learn that a physician was still practicing leeching as a treatment, or initiating treatment based on the ancient theory of "humors." He would in all likelihood, be deprived of his right to practice, and yet, there are those who would lock the chiropractor

into the dark and dangerous prison of ignorance, by catapulting him backward into the last century by depriving him of the essential first phase of any therapeutic procedure.

This is 1981, and the chiropractor exists in this century. He functions as a primary provider, a portal of entry practitioner. He is an integral and a vital segment of the team of professionals who are entrusted with the health care of this nation.

Higher education consists of a certain number of core courses, that is, courses dealing directly and exclusively with a subject matter, and satellite courses dealing with specialized subject matter from a consideration of etiology, diagnosis, pathology, treatment and prognosis.

In a sampling of the curriculae of chiropractic colleges accredited by Council on Chiropractic Education, the body empowered by the Department of Education of the federal government, the following information was extracted:

Core courses in diagnosis = 900 Classroom hours
Satellite courses = 1875 Classroom hours
Total diagnostic curriculum = 2775 Classroom hours

It is long past the time that antagonists, both within and without the profession, take off the blinders, and look at today's facts, not yesterday's fallacies. It is time, too, for the courts, the judiciaries, and the legislature of this good land to act objectively and upon facts, not emotionally and upon hearsay. Justice may well be blind, but there is no excuse for her to be ignorant. ☐



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PLEURAL EFFUSION — ROENTGENOGRAPHIC SIGNS

by Sharon A. Jaeger, D.C., D.A.C.B.R.

Pleural effusion is by far the most common and most important abnormality affecting the pleura. In health, fluid is formed at the parietal pleura and absorbed at the visceral pleura. Transudation and absorption depend primarily upon a balance between hydrostatic pressure which forces fluid out of the capillaries and osmotic pressure of the blood, which draws tissue fluid into the capillaries. Despite this usually effective combination of forces, physiologically occurring pleural fluid can be visualized roentgenographically in a significant percentage of normal healthy humans.

When fluid accumulates, it gravitates first to the base of the affected hemithorax where it settles between the inferior surface of the lung and the hemidiaphragm, particularly posteriorly, where the pleural recess is deepest. As the amount of fluid increases, it spills out into the costophrenic recesses, posteriorly, laterally and anteriorly. With even more accumulation, the fluid spreads upward in a "mantlelike" fashion around the convexity of the lung, tapering gradually as it rises higher in the thorax. The upper and medial borders of the pleural fluid opacity are ill-defined but usually form a concave arc upwards along the lateral costal wall (the meniscus sign).

As the lung relaxes toward the hilum the mediastinum may be displaced toward the contralateral side or it may stay in the center. Whenever deviation is noted toward the side of the effusion major atelectasis should be considered.

Etiologies of pleural effusion include such entities as tuberculosis, malignancy, congestive heart failure, rheumatoid arthritis and other collagen diseases, pulmonary embolism, and trauma.

In order to make a roentgenological diagnosis of pleural effusion, usually 200-300 ml of fluid is necessary. Roentgenographically we should look for such findings as:

On the upright PA chest film
elevation of a hemidiaphragm
a lateral shift of the point of greatest convexity on the dome of the diaphragm (sometimes more pronounced on an expiration film)
the distance between the "pesudodiaphragm" and the gastric air bubble (magenblase) is greater than 2 cm.
the lateral costophrenic angle is obliterated
mediastinal shift as described above

On the lateral projection
obliteration of the posterior recess
thickening of the fissure lines — fluid may accumulate between the septae



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An additional study that may be of benefit in evaluating a patient with suspected pleural effusion is the lateral decubitus view taken with the patient lying on the involved side. This projection will demonstrate the diagnostic layering of the fluid. By shifting the fluid, this film may also show an underlying mass suggestive of the etiological agent.

The careful observation of the above-noted findings will help you in using the diagnostic tool of x-ray in evaluating your patient when the possibility of pleural effusion exists.

References:

1. Fraser, Robert, Pare, Peter: Diagnosis of Diseases of the Chest, Volume 1, Philadelphia: W.B. Saunders 1977, pages 568-570, 575-576, 580-583, 316-317.
2. Sutton, David, A Textbook of Radiology, London: Churchill-Livingston 1975, pages 304-312.
3. Hospital Medicine: Pleural Effusion: Points to Remember In Making the Diagnosis on X-ray, June 1981, page 40 I.

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BOOK REVIEW

"AN INTEGRATED PRACTICE OF CHIROPRACTIC"

by George P. Buell, D.C. & William B. Risley, D.C.

I'm sure that many of us have long thought it would be nice to have a chiropractic volume comparable to "The Merck Manual" of medicine. Unfortunately, "An Integrated Practice of Chiropractic" is not that volume. It is, however, an earnest attempt in that direction.

Covering some 345 pages, the book is divided into 13 major sections under the following titles:

The Nervous System — The Reproductive System — The Elimination — The Cardiovascular System — The Skin — The Respiratory System — The Muscles — The Joints — The Digestive System — Febrile Disorders — Miscellaneous Disorders — Chemical Essentials and General Information.

This is followed by a Dictionary of Root Words, Suffixes and Prefixes, a Glossary of Terminology and the Index.

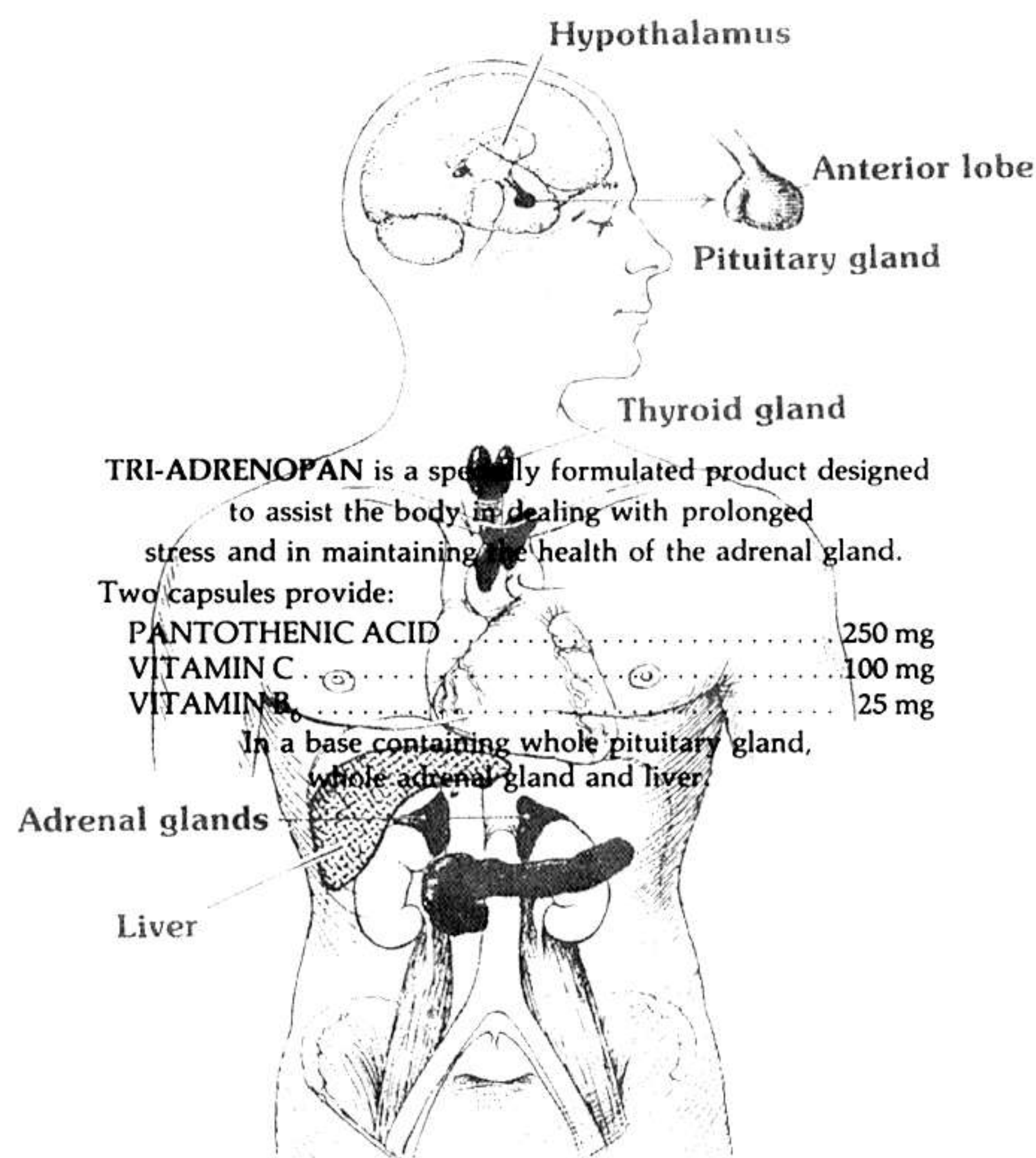
Each of the sections covers a variety of conditions that pertain to the heading. There is then a descriptive text concerning the condition which is broken down into the headings of Description, Symptomatology, Chiropractic Analysis, Specific Treatment, Adjunctive Procedures and Prognosis. By no means did I personally agree with all of the text, particularly the therapy, but for the most part it made sense and is a step forward.

The volume lists for \$25.00 but that was at its first printing date of 1963. After telling you all of this, I must add that it might be out of print. I purchased my copy several years ago and feel, however, that it is worth the effort to try to find a copy. The publisher was listed as The MMM Publishing Company, New Eagle, Pennsylvania. If all else fails, maybe they could help. To be exposed to ideas of those who have thought constructively about things of common value is worth almost any effort.

Richard H. Tyler, D.C.

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NEWS OF INTEREST

It was recently disclosed that a major contributing factor to the profession's loss of the just concluded anti-trust suit against the AMA was the recitation to the jury of the seminar material from a practice improvement guru's carnival. It didn't take the average citizen much time to think ill of a profession whose members sanctify the purveyor of this sleazy cornball garbage. A profession whose members feel that they can't succeed without regular doses of sideshow hoopla nonsense can't be one to be taken seriously. For those with a short memory, Sen. Edward Kennedy read the same kind of material on the floor of the United States Senate and that almost kept us out of any kind of Medicare coverage. When will we ever grow up sufficiently to put away all those "toys" that leave us open to professional ridicule? □

FUNCTIONAL OR IRRITABLE BOWEL SYNDROME

by Jeffrey W. Greene, D.C.

DEFINITION

The functional or irritable bowel syndrome is a symptom-complex, characterized by a variety of symptoms, including altered bowel function with or without chronic abdominal pain; dyspepsia, nausea, vomiting, areophagia, flatulence, and vasomotor phenomena.

ETIOLOGY

The cause of the irritable bowel syndrome is unknown. The disorder is attributed to an abnormality of intestinal motility combined with a heightened pain response to bowel distention rather than to an increased volume of intraluminal gas. Paradoxically, decreased bowel motility is associated with diarrhea and increased motility with constipation.

CLINICAL FEATURES

1. The syndrome is a chronic illness with frequent relapses. However, the onset is abrupt in about one-fourth of the cases.
2. Symptoms generally recur throughout life. The diagnosis should be made with great caution in older patients who have not had symptoms at an earlier age.
3. The predominant clinical expression is irregularity of bowel function with or without abdominal pain. Most patients complain of frequent, small, loose stools rather than true diarrhea. Constipation is usually described as the passage of scybalous or pencil-like stools. There may be excessive mucus in the stools, but blood and pus are never present. A common pattern of defecation consists of the passage of a hard stool in the morning followed by several loose stools later in the day.

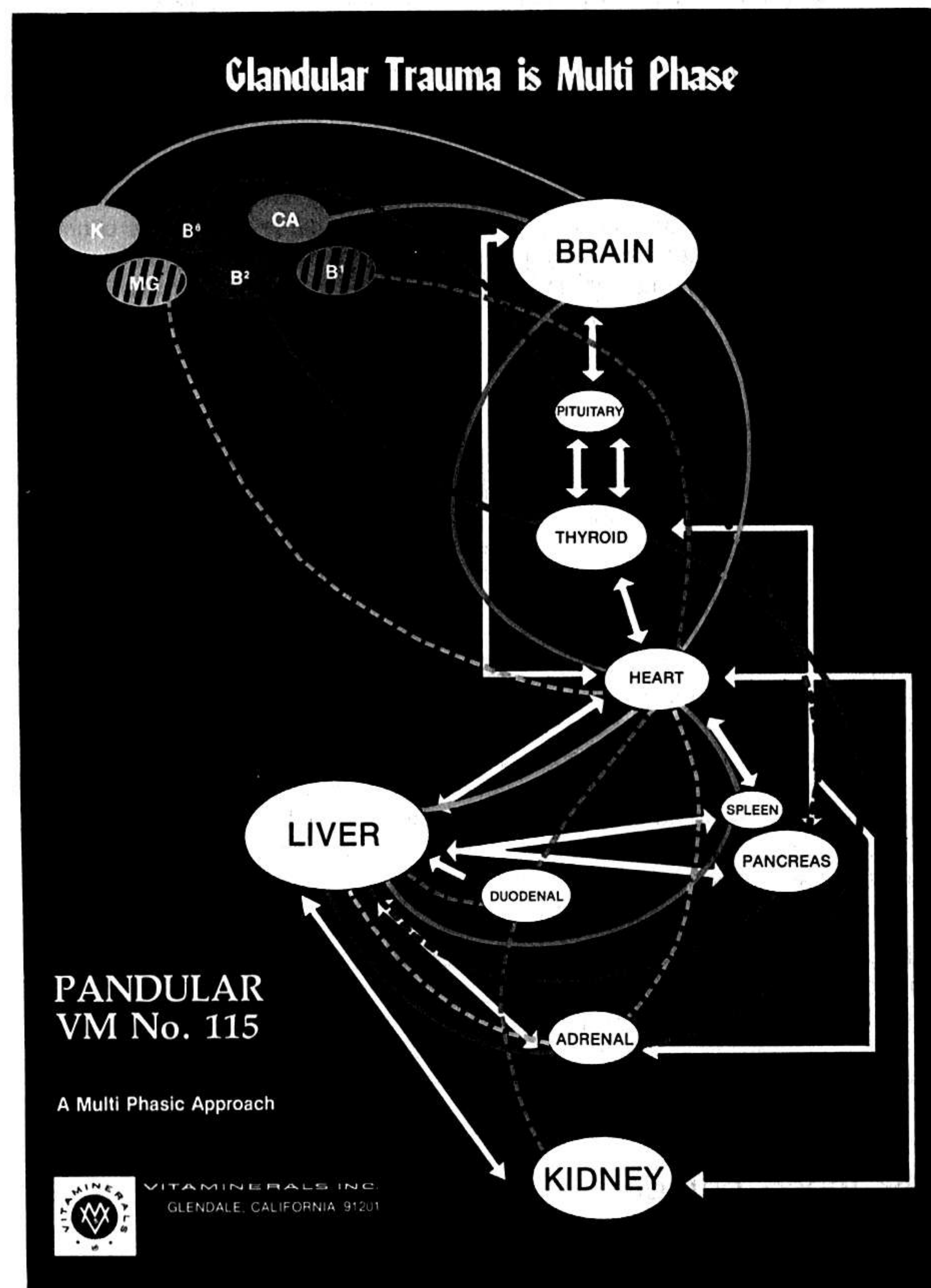
4. Abdominal pain is present in the vast majority of patients. It is frequently ill-defined, but is most often localized to the lower abdomen of left lower quadrant. Relief of pain may be obtained by the passage of flatus or feces.
5. Gaseousness, bloating, excessive flatulence, and dyspepsia occur commonly.
6. Vasomotor phenomena (faintness, flushing, sweating, palpitation) are noted frequently.
7. The occurrence of nocturnal pain or diarrhea, incontinence, fever, dehydration, and electrolyte disturbances suggests organic disease rather than an irritable bowel syndrome.
8. Physical examination is negative, but may reveal tenderness over the colon.

DIAGNOSTIC APPROACH

1. A careful history and physical examination, including pelvic and rectal examinations, should be performed to rule out organic disease and detect psychic disturbances.
2. Initial workup.
 - a. CRC.
 - b. Urinalysis.
 - c. Stools for ova, parasites, and occult blood.
 - d. Fecal smear for leukocytes. The presence of polymorphonuclear leukocytes indicates inflammatory bowel disease and practically excludes the diagnosis of a functional bowel disorder.
 - e. Proctosigmoidoscopy.
 - f. Trial of milk-free diet, a crude screening procedure for lactose intolerance.
3. Subsequent workup.

If symptoms persist, and the initial workup is negative, additional studies are advisable.

 - a. Barium enema, upper GI series, and small bowel study.
 - b. Screening for malabsorption (see section Chronic Diarrhea).
 - c. Colonoscopy.
 - d. Lactose tolerance test.
4. Other procedures. When the symptomatology is persistent or intractable, and the workup is negative, additional investigation may be warranted to rule out biliary tract diseases, porphyria, the carcinoid syndrome, malabsorptive states, amebiasis, and giardiasis.
5. If all of the foregoing studies are negative, it can be safely assumed that the patient is suffering from a functional bowel disorder rather than organic disease.



**MEMBERSHIP IN THIS COUNCIL
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We have always had to contend with the loud and raucous voices of the "straights" in our profession who are working night and day like termites to restrict our scope of practice to their narrow concepts of spinal technicians. But now for over a decade we have a new element "within our fold" which Dr. Tyler referred to in his Editorial in the July 1980 *Chiropractic Family Physician*. This is a specialty which has for over a decade claimed in lectures all over the country to be "Total Chiropractic." We have no quarrel at all with this or any other council or specialty, but any council or specialty which misunderstands this profession so much as to hope to take over the entire profession in its own image is entirely out of line, and the profession must be alerted to its malignant objectives.

Our profession is kept under scrutiny by the U.S. Department of Education in Washington which grants approval of the Council on Chiropractic Education. You must realize how important it is to the total profession that the record year by year show the Council on Diagnosis and Internal Disorder to be a large and active council of the ACA. If we can establish in the Department of Education in Washington, D.C. records year by year that our profession not only claims to place strong emphasis on diagnosis as a professional responsibility but has a strong and active Council on Diagnosis, it will be a power in assisting CCE to continue to receive the Department of Education approval. At this point in time, I state to you, as a member of CCE for 14 years, that probably the greatest service this council can render to chiropractic is a record of being a large and active Council on Diagnosis. Actions speak louder than words. If you have let your membership lapse — get that checkbook out NOW and become active again. If you have not joined, get the application in the back cover of the *Chiropractic Family Physician* and send it in with your check. Great benefits can accrue to the profession by this council showing up as having wide membership participation.

In conclusion, the cost of printing and postage for the *Chiropractic Family Physician* have risen to a point that it must be supported by a large council. If you believe in our message — join now. ☐

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CHAPTER XIV —
MALE GLANDULAR DISORDERS

While men statistically do not employ health care services as frequently as women, that does not necessarily reflect any credit to their strength or superior level of health. In fact, it is also statistics which seem to provide the strongest evidence against any such false conclusion. The latest figures show that women live an average of at least four years longer than men.

In this chapter, which will deal particularly with disorders which are specifically male, we will endeavor to cover the entire life span from birth to death, but dealing with those conditions which are related only to personal experiences and which have been handled successfully without employing either drugs or surgery.

Due to the fact that women are assigned by nature with the burden of pregnancies with all its vast array of challenges which this function embodies, female problems seem to far outweigh the male problems. Nevertheless, male disorders are still very important and must be given a high priority in the practice of the family physician. We have found men and women both to be pitifully uninformed about their bodies and normal and abnormal functions, especially in relation to the glandular systems.

Women in general have more patience to give their bodies time to respond to care and treatment than men. Men are inclined to expect instant cures, often in relation to most serious and complex disturbances of their physical well-being. This seems to be a male characteristic as male doctors seem to be as impatient as other males when the disorders are personal and their own discomfort is at issue. This male impatience is something that doctors with male patients have to learn to live with and to humor them without patronizing.

In this chapter we want to stay away from diseases which may afflict either sex such as mumps, measles, scarlet fever, etc., even though each sex may be affected differently because of being male or female, with their characteristic different functions. The differences in the glandular systems account for special reactions in each. It is hoped that the variety of case histories to follow will make this quite clear. We cannot discuss every kind of case or give case histories for each. We will confine the case histories to those that are typical, fairly common or so unusual as to throw some light on the entire subject of male glandular disorders.

We believe our experience with a fairly wide variety of disorders which is peculiar to male human beings is pretty strong evidence of the effectiveness of NVD in diagnosing and/or treating their problems. We feel safe in challenging anyone to cite any other method which will prove equally effective in eliciting consistently uniform glandular responses as we have shown in undescended testicles, stopping of leaking of serum from a mature male breast and restoring and maintaining normal prostate functioning in elderly men, and relieving them of the necessity of surgery. While we have listed only a few cases of elderly men, our experience covers many dozens of cases and these patients are uniformly satisfied, except where laboratory tests reveal serious pathology, and require referral.

The prostate gland is subject to more problems among men who practice celibacy than among married men who have a normal expression of sexual activity. "What we do not use, we lose." In terms of anatomy, tissue that is not called upon to function with a normal amount of activity is not as healthy as tissue that is normally active. Among men who have a normal amount of sexual activity, any prostate trouble usually clears up with our methods in from one to three treatments. Periods between treatments usually cover a considerable time span, often for a number of years. Among men practicing celibacy, the gland very often is boggy and unhealthy and requires much more frequent treatments. We do not mention this facetiously as our office has been near a large monastery for many years where there is a large population of priests and brothers. Our office has been frequented often by them. The anatomy of the gland is such that the urethra passes through its center so that the muscular fibers of its structure act as a compressor to provide velocity for the passage of fluids. Anything which causes the tissue of the gland to proliferate (swell) or become congested naturally interferes with the voiding of urine and seminal fluids. Since we are opposed to prostatic massage which probably creates more problems than it benefits, obviously the treatment of choice is one which will de-congest the prostate tissue and relieve its pressure upon the urethra. We are doing this with consistent success using the gloved index finger pressing against the anterior cusp of the internal anal margin, with the patient lying on the right side, knees drawn up against the chest.

In prostate congestion for whatever reason it will be very tender. This only has to be held firmly from one to five minutes to relieve the pressure of the gland against the urethra and permit free passage of urine. The treatment may be improved by contacting a paravertebral point at D5 and 6 (either side) while

holding the other contact. For more than twenty years we have also used the rectal ultrasonic electrode at 2 watts for 10 minutes. This modality used at low wattage is a very effective decongesting agent as it relaxes the precapillary sphincters and permits reactivation of many thousands of capillaries which are inactive in congested tissues such as we find in abnormal prostate glands.

In making the rectal prostate gland examination one should also examine both right and left just inside the anal margin. If supersensitive, it indicates inflammation of the vas deferens. It should be treated in the same manner by holding the contact until the tenderness is dispelled. In acute cases of either prostate or vas deferens, the patient should be seen again in from one to three days to repeat the treatment. The patient is usually amazed that tenderness has all gone and that explains why he is urinating so much more freely.

DEVELOPMENTAL DEFECTS

In the now-famous "Iatrogenic Diseases" by D'Arcy, no one can miss the hazards of "the pill" to the women who use it or have used it, but we are unable to find much evidence of research regarding the effects of "the pill" on the later offspring of "its" users. I had not given this any recognition but recently I have had several cases of undescended testicles in boys. I observed that in Ciba Vol. 4, Page 73, five different groups of conditions are tabulated and variations within each group, so we are impressed that it is not a simple subject nor one that has been neglected in studies.

Case #1

The 34-month-old son of one of my patients had been observed by his grandmother to have undescended testicles. I asked the mother about it and she was not anxious to talk about it and was inclined to defend the boy with an attitude that there was nothing wrong with him. During the course of her treatment I explained some of the undesirable problems in development that might occur if descent of the testicles was delayed too long. Before she left I suggested that she get him in for me to see whether there really was any problem. She apparently was impressed by what I had explained to her and made an appointment to bring the boy in the following week.

As I laid the boy on the examining table in the supine position it was immediately apparent that both testicles were lying in the abdomen immediately superior to the pubis, and the scrotum was empty on both sides. I first treated the lateral borders of the pubis bone and the left 6th cervical for shock from birth. I treated the testicle reflex area (see chart), the anterior and posterior pituitary areas with the secondary contact on the trapezius muscle. I also contacted the areas for the parotid gland and carotid sinus. On the brain I treated the anterior fontanel, the frontal emotional areas, the temporal tips and the panoramic areas above the zygomatic bone. Finally I adjusted the boy's neck and back. An appointment was made to see the patient in one week. This was new to me and I did not know how long it would take or whether there would be any response at all.

When the boy was brought in the following week and placed in the supine position and his shorts pulled down, it was instantly apparent that the previous treatment had been successful. Both testicles were resting comfortably in the scrotal sac.

I nevertheless treated the boy again exactly as I had before, as I wanted to make as certain as possible that those testicles stayed down where they belong. I cautioned the mother to keep watch and to bring him in at once if there was any sign of withdrawal from the scrotum. This treatment took place over a year ago and as I see the boy from time to time we know that the testicles are well established in their normal position in the scrotum.

Case #3

This gland apparently may give trouble at any age, but we expect to find it more frequently in the elderly and in middle age. We had to readjust our thinking on this subject about eighteen years ago. One of our patients called and said her little four-year-old son was in misery because he could not urinate. He was a shy little fellow and had been to a children's party and had held himself too long before going to the bathroom — then he could not go.

His mother had taken him to the pediatrician and he casually stated that the boy had prostate trouble, but did not offer to do anything about it. That was when she called us for the situation was rapidly reaching a state of crisis. We told her to hurry and get him in. We were curious to see a boy of four with prostate gland trouble. As soon as she got him to the office we put him on the table and checked the anterior internal cusp of the rectum. It was as sensitive as any ever to be examined. The area was held three or four minutes while he squirmed like a worm on a hook, but then it relaxed and he was sent to the bathroom. Standing at the door we could hear him start a good stream that lasted quite a while before he was completely relieved from his hours of agony. That day I learned that age is no arbitrary factor for prostate gland problems.

Case #4

Much was learned from this case and any clinician reading the following should be given a new insight into such cases and how they may be handled successfully. A 46-year-old male former patient called in for an appointment. His duodenal ulcer had been cured about a year before with NVD procedures. When he appeared for his appointment we learned right away that he was not concerned about the ulcer — apparently seemed to have forgotten all about it. His puzzled anxiety now was about his left breast which was leaking serum. Examination of the breast showed some swelling, redness, considerable tenderness and a slow oozing of serum. Mumps and the parotid gland came immediately to mind. The patient's response to inquiry about mumps brought forth the surprising but anticipated information that he had mumps when he was 32 years old and that his left testicle had swollen up to the size of a cantaloupe. He was assured that his present problem with his breast was directly related to the belated bout with mumps. He was assured that there was very good reason

to expect that by our methods (NVD) the serum could all be drained out and would be most unlikely to ever recur. He was prepared to cooperate and treatment was directed to the following contacts: parotid gland, both testicles, left mamma, pituitary, thyroid, adrenals and last but not least, the left femoral lymphatic. (If the right breast had been discharging serum we would also have treated the right subclavian lymphatic release.)

Following treatment, the patient was given an appointment to come in again in three days. When he came in he reported that half a cup of pus and serum had been released after the first treatment, it was not anticipated that much more remained to be expelled. Treatment was given again the same as on the previous visit and another appointment given for four days later. When he came in he reported that no more serum or pus had been released. A third treatment was given, the same as the first and second, and the patient was instructed to call in and report progress. He reported once a week for a month and no more fluid had appeared from the breast. Footnote: Fifteen years later this patient came in for a knee problem. He had never had any further problem with the breast.

Case #9

This 76-year-old white male came to the office on August 10, 1979, due to indigestion and general abdominal pain. This was cleared up promptly with NVD in three treatments and dieting guidance. He was in again on September 20, 1980, with indigestion and enteritis due to dietary indiscretion. This cleared up in two visits, again with NVD treatments and further dietary counseling.

On June 15, 1981, he returned for help with hemorrhoids and difficulty with urination. He was treated with ultrasound to the rectum for both hemorrhoids and prostate gland congestion. This did not give immediate relief but the reflex treatment to the prostate did restore his relatively normal urination function. This patient returned a week later to provide a follow-up to see that his progress was satisfactory. We were satisfied and expect him to enjoy reasonable comfort for some time.

This case portrays a typical clinical experience in our handling of elderly gentlemen with prostate difficulties. In cases such as this one we expect immediate and clear and positive benefit. When this does not occur, we order laboratory tests for prostatic acid phosphatase and erythrocyte Sedimentation Rate, particularly to determine without delay whether or not we are dealing with abnormal function or pathology.

Case #10

A 76-year-old white male who had been a patient over 15 years ago came in with right lower back pain and pain down his right leg. The working diagnosis which we made was sciatica. It was explained to him that this usually originated from the prostate gland in men and proceeded to make a rectal examination. The prostate area and right vas deferens were more than moderately sensitive just inside the rectal margin. The contacts were held until the sensitivity ceased.

Our record shows no spinal or pelvic adjustments of articulations of that area. The only adjustment made was in the cervical area of the spine. The patient left the office without pain in the lower back or the pain down the leg.

The patient returned again as per appointment sixteen days later. He was having no pain in either area but standing in front of the plumb line we found his pelvis to be over one inch to the right of the plumb line. He was given the De Jarnette 1B anterior treatment to stabilize his psoas major muscles and no other treatment was given. His first visit was September 12, 1979. This case is given to show the relationship between the prostate gland in the male and sciatica. Before we learned about this relationship our success with sciatica was about as poor as most others who depend only on osseous adjusting. There are atypical individuals who may be baffling, but now we feel reasonably confident about giving sciatica cases consistent relief, and usually long-lasting relief. □

LETTERS TO THE EDITOR

Dear Dr. Tyler:

I have been very grateful for every issue of the Chiropractic FAMILY PHYSICIAN that has come my way.

One issue in particular has been of immeasurable value to me, not in money, but in pride and satisfaction. It was the issue in which one contributor explained how he had successfully handled a case of psoriasis, a supposedly incurable disease. His success persuaded me to accept a similar case. The case was that of a beautiful young woman in her early 30's who had suffered from the disease since early childhood. Presumably for that reason she had never married. Thanks to that article she now has only the slightest traces of the condition and is married to a fine young clergyman.

Now she is eager to thank the chiropractor whose procedure I have followed and she wants also to tell her story in some publication that is widely read so that many other people cursed with psoriasis can look forward to relief.

My problem is that I am one of those people who look for a special place to hide something precious and then forget where they put it. Can you possibly give me the name and address of that chiropractor? I think the issue came out late in the year 1979.

Sincerely yours,
Clarence W. Weiant, D.C., Ph.D.

AN IDEA WHOSE TIME HAS COME

By Dr. Marvin S. Dayan, D.C.

It is not new to us that the straight chiropractor has advocated a split in our profession. Up until now, we have resisted this at first glance as an extreme and untenable idea. However, upon much deliberation and serious thought, it seems to this writer that this proposal has merit, and that the idea is not as horrendous or alien as previously thought.

The struggle between both factions has caused such strain and strife within the profession, that it has been a major impediment in our professional growth.

This divisiveness is indeed an effort in futility and is counter productive. Therefore, upon many, many sleepless nights, and a great deal of careful consideration, I have come to the conclusion that this split is, "an idea whose time has come."

I have attended meetings where the staunch advocate of the straight chiropractor presented to the profession, a so-called legal brief espousing his ideas of two types of license within the profession, and deliniating its scope and restrictions. At the time of the proposal it was met with thunderous silence. I doubt that the two extreme philosophies are reconcilable. I feel that each should go their separate way. Indeed, the time has come for us to choose our own path.

We are a dynamic, growing, vital profession and we cannot be shackled and hamstrung by a status quo mentality. We as a profession, have a great potential for relieving many of the ills in our society today. If we stand still and only advocate the moving of the bone, that is as far as we will go.

We have great men in our profession who are innovators, researchers and educators with new ideas, thoughts, and techniques, that have stirred the caldron of chiropractic thinking. Just think of the collective intellectual abyss we would have, if the likes of De Jarnnett, Bennett, Janse, Gonstead, Goodheart and others were narrowed into the myopia of the status quo philosophy. Because of their collective intellectual curiosity, coupled with their overt audacity to ask why, our profession has been given a new direction, nay a new lease on our professional lives. Pigeon holes and progress are incompatible!

These men and their ideas have not only advanced the thinking of our profession, they are also making firm imprints on the other healing arts. Hence, the other professions are prevailing on their time, and we cannot secure them for our own seminars.

This thinking is anathema to the straight practitioner in this space age.

I feel that we are hampered and restrained and put in a straight jacket by this type of strictured thinking. There is only one recourse open to us, and that is to sever the negative!

If a profession is restrained from going forward, standing still is overcome by the momentum of progress, thereby, we can only go backward.

NUTRITIONAL THERAPEUTICS FOR ALLERGIES

by Eve Campanelli, Ph.D.

In my own practice, I have found that poor diet is the culprit in at least 60% of most allergy problems. Allergies do not just manifest in a runny nose, they can make themselves known through acne, rashes, fatigue, dizziness, bloating, etc.

The following herbs and food suggestions may be tried to help the body get rid of the mucous condition that allergies thrive on, and strengthen its resistance.

FOOD

For 1 week have the patient eat only *fresh* fruits and vegetables and drink only water and herb teas with fresh lemon. If this is too difficult add to the steamed vegetables or salads: 1 to 2 handfuls blanched almonds, 1 to 3 cups brown rice or millet, depending on the patient's size. Fresh fish cooked with lemon and parsley may be used 3 to 5 times a week.

do not use:

milk — any kind, salt, sugar, red meat, wheat, anything refined,
dairy — any kind, eggs,
soft drinks — any kind, coffee, bread, tomatoes.



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After this 1st week, add back in one food at a time, each day, and see which foods bring the symptoms back.

HERBS — dosages per day

name	capsules	decoction	infusion	tincture
cubeb berries	two 3 x	2 tbsps. 4x		as directed
Lobelia and capsicum	1 after meal 2 days then increase to 2 or 3 one 3x			
ginger root			1 cup 3x	
thyme leaves			½ cup 3-4x	
violet lvs. ½ cup 3 x	one 3 x		½ cup 3 x	
chapparell & Oregon grape rt	two 3 x or with above 3 in combination	two 3 x		
Fenugreek seeds	two 4 x		1 cup 3-4x	
dandelion rt.	one 3 x		1 cup 3-4x	

Use any of the above in combination of equal parts, as they are available to you.

Small children

Cubeb berries	one 3 x			
fenugreek & dandelion	one 3 x			as directed

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BOOK REVIEW

CRANIOPATHY

by Nephi Cottam, D.C.
Edited revision by Calvin Cottam, D.C.
& Reid Rasmussen, D.C.

There seems to be a renewed interest in cranial adjusting. A great deal of this interest has been sparked by the dental profession through their relatively recent preoccupation with the TMJ syndrome. They have become enraptured (and justly so) with all the ramifications found in the creation and maintenance of structural therapy through the proper occlusion of the mandible. What chiropractors have been saying for so long is now being "discovered" by other professions. To maintain their TMJ corrections, the dentists have been referring their patients to osteopathic and chiropractic physicians for manipulation of the cranial vault. Hence, what was once thought of as a kind of "back-room, pseudo technique" is emerging as a viable and legitimate structural concept.

Before anyone formalized the idea, Nephi Cottam discovered and published notes which promulgated the fact that the sutures of the skull do indeed move and that they could be moved by one trained in the procedure, to the ultimate benefit of one's patients. A few years after Dr. Cottam's philosophy of cranial adjusting was given to the profession, an osteopath by the name of Sutherland told the osteopaths about the new concept. This was the beginning of a controversy over who was the true discoverer of the cranial adjusting idea. I feel that there is too much time wasted by the "I'm first" folks. Who cares? Does it work?

With the emergence of cranial adjusting into the arena of "respectability", you'll probably find that a number of books and courses on the subject will begin to spring up. Unfortunately, I know of no course taught in our schools while it's been taught in osteopathic schools for years. Isn't it interesting how we discover something and then let others use it, while we stand with our hands in our philosophical pockets?

So — here we have a book, or more aptly a set of notes, by Cottam, that outlines and illustrates 92 cranial and related techniques. It sells for too much — but what doesn't these days? The notes are divided into two parts — "Craniopathy for You" and "Craniopathy — Its Use for Others". Since prices fluctuate, I suggest that you contact the authors if you're interested. I have the notes and I found them graphic and useful.

Information may be obtained by writing Calvin Cottam, D.C., 1017 South Arlington Ave., Los Angeles, CA. 90019.

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"A chiropractor should be able to care for any condition which may arise in the families under his care, the same as a physician," page 789 "The Science, Art and Philosophy of Chiropractic" by D.D. Palmer.

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THE CHIROPRACTIC FAMILY PHYSICIAN

SEPTEMBER, 1981

VOL. 3, NO. 6



ERNEST G. NAPOLITANO, D.C., LL.B., LL.D., Sc.D., Ph.C.

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SEPTEMBER, 1981

VOL. 3 NO. 6

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TRIBUTE

**ERNEST G. NAPOLITANO,
D.C., LL.B., LL.D., Sc.D., Ph.C.**

It always seems that when the great dwell among us we seldom recognize their contributions. We wait until they have passed away and then do a movie on their life. Only recently has the chiropractic profession moved in a direction that might demonstrate a lasting measure of honor and gratitude to those leaders who have helped shape the academic and professional destiny of our profession.

To even the most casual student of chiropractic the name of Ernest Napolitano brings almost instant recognition. Dr. Napolitano has been heaped deservedly with many honors from his profession and from society. In 1978, he was inducted into the Chiropractic Hall of Honor where a bronze bust of him now stands on the Texas Chiropractic College campus. He has been listed in Who's Who International Registry, Who's Who in New York State, International Who's Who in Community Service, Outstanding Americans — Bicentennial Edition, Community Leaders of America, and Who's Who in the East.

The list of awards is endless and those familiar at all with Dr. Napolitano are well aware of his many achievements. Our purpose in placing him on the cover of this issue is not to honor him as an individual, for he has had many richly deserved honors already. Rather, he represents an academic ideal personified. In 1959 he became the president of the Columbia Institute of Chiropractic which is now known as the New York Chiropractic College. Over the years, Dr. Napolitano has taken an unimposing structure on the west side of New York City and forged it into one of the most effective academic institutions on one of the most beautiful campuses in the country. NYCC is fully accredited and with Dr. Napolitano's continued leadership will remain as a paragon of academic eclecticism.

The students are the "clay" with which the profession works. With the hands of a sculptor like Dr. Napolitano, we can produce masterpieces. ☐

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PRESIDENT'S PAGE

The original purpose of this council was to provide educational programs to increase the expertise of our members and to make available such post-graduate courses that would lead to diplomate status for those who desire to achieve this status in our profession.

Specialty groups within our profession have not met with the approval of all simply because it appeared to be that we were trying to go "medical" in our activities. This is the farthest from the truth! It is our desire to provide post-graduate level education within the limits of our scope of practice and nothing more. To accomplish this much would be far reaching and highly effective.

Unfortunately, our council has been working with various committees within the structure of the ACA and has met with very little success because those in charge were not able to handle it effectively. Consequently, we are at a standstill at the present time. However, we have been persistent in our efforts and the new committee in charge knows that we intend to accomplish our goals this year and has been so informed. At present, our future lies in the hands of the CCE, and this committee is headed by Dr. Ernest G. Napolitano of NYCC, and I feel that we have, at last, found someone with whom we can work. I am personally committed to completion of this work in 1982.

The need for diplomates from this council was emphasized recently when one of our mid-western colleges stated that they were prepared to put on classes leading to diplomate status in our council but they were not able to find qualified doctors to teach. This points out the need for qualified personnel, not only for instructors but for doctors in the field who need someone in their area with whom they can consult.

The solution lies within our group. We must support our council's efforts and encourage those who desire to further their education to higher level of post-graduate excellence. As Dr. Russ Earhardt says, everyone does not need to or desire to obtain a diplomate status, but for those who do, we should provide the means to do so.

As this diplomate program is made available, if you do not wish to participate, please urge those who do to make the effort and back your particular chiropractic college as they endeavor to put on these educational programs. ☐

Ronald Sibson, D.C.
President CDID

The journal will hereafter be sent outside the United States to members of the Council and to subscribers only.

EDITORIAL
"Misplaced Power"
by Richard H. Tyler, D.C.

Think for a minute. Do they — the medical people — do they have a cure for cancer? Do they have a cure for cystic fibrosis or for emphysema or muscular dystrophy? No. After some forty years of collecting millions or even billions of tax-free dollars through the American Cancer Society, the only thing we have to show for it is the knowledge that if you extirpate some portion of your body soon enough, you might survive. If any other company were run like that, you'd have fired the personnel years ago. Still, all these phony organizations go along sucking up the public money and showing nothing for it but another ridiculous telethon.

A few years ago, I organized a birth defects screening clinic for a local Kiwanis Club. It has nothing to do with therapy or the promulgation of any health philosophy, just screening to inform the parents of the possible problems their child might have in the future. A number of members of differing health disciplines volunteered to work along with the chiropractic physicians in the program. Naively, I contacted the March of Dimes hoping that they would give the enterprise some much needed publicity. At first, all was sweetness and light. I had lunch with a field representative and was assured of cooperation. Then abruptly all support was withdrawn on the "advice" of the medical committee. Anything with chiropractors, optometrists and podiatrists could not be tolerated. Here then was a *public* organization supported by *public* contributions, but totally controlled by medicine.

There are many other instances of medical and special interest control over publicly-funded organizations. Wouldn't it be nice if a public audit was required annually so that the well-meaning people who are being fleeced every year could find out just where all that money is going?

All of the preceding is bad enough, but it is particularly infuriating to see organized medicine blatantly control the courts to the extent that it would endanger the health and safety of our children. Two recent and highly publicized cases had legal authorities taking children away from their parents because they wouldn't obey the orders of the medical profession. These self-appointed guardians of the health of mankind will allow no dissent. The judge, who knows nothing more about health than organized medicine tells him, then arrogantly orders the arrest of any parents who have the nerve not to do as the medical profession dictates. It would be different if medicine had a cure for the cancer these children had — but they didn't and still don't. For thirty years they proclaimed that the use of laetrile was quackery. Maybe so — but only recently have they done any research. On what, for the last thirty years, were they basing their conclusions?

I've had it up to here with the glorified "research" and demagoguery of medicine. I'm just as fed up with members of the chiropractic and other healing arts

(Continued on page 29)

**THIS ISSUE COMPLETES THE THIRD YEAR OF
PUBLICATION OF THE CHIROPRACTIC FAMILY
PHYSICIAN**

All issues mailed were not less than 11,000 copies, except the first one. All fifty states were covered and copies also went to Canada, Europe and Australia. We have wanted to know if chiropractors in *great numbers* really want to be qualified physicians, or just want to be known as physicians without doing anything extra to achieve that distinction. We have our answer in two ways: Classes in the colleges, which teach a great deal about things that enable a D.C. to practice as a family physician, have great difficulty getting together classes of one or two dozen doctors who sincerely want to qualify and learn that it takes to qualify. At the same time we see a huckster comedian holding a 'seminar' (?) in Las Vegas and drawing 1500 D.C.'s from all over the country spouting about how to use chiropractic to rip off the ever-trusting public. We have to conclude that only a chosen few really want to qualify to be chiropractic family physicians.

The second way we have our answer has been in our three years of publication of the *Chiropractic Family Physician*. It is obvious that if there had been or is an overwhelming percentage of the profession who sincerely want a broad family practice, the membership of the Council on Diagnosis and Internal Disorders would have risen to several thousand members. Since we cannot maintain a membership over 500, again we have to conclude that only a chosen few really want to qualify to be chiropractic family physicians.

We have had so many compliments on the quality and content of our Journal from a wide spectrum of perceptive and influential doctors from all over the country, we do not believe this lack of response can be the fault of the *Chiropractic Family Physician*. We have to recognize the simple fact that not enough doctors of chiropractic care to be family physicians to maintain a large enough membership with Council in Diagnosis and Internal Disorders to continue to publish this Journal, and support it.

With the ever-rising costs of mailing and printing and the inevitable fact of the mortality of man, it appears that only a miracle can justify continuing this Journal into its fourth year.

Dr. Richard H. Taylor is dedicated and deeply committed to the continuation into a permanent Journal to the elite in the profession, but he will have to have the support of a much larger Council than we presently have, and someone to take the place of this writer, who has borne the technical burden of securing and maintaining advertising, and nursing each issue through the technicalities of publication. The accumulation of the years prevents my further participation in the work I have given in the past.

I wish particularly to recognize all the loyal advertisers who have generously supported our efforts through the years. I also wish to recognize all of you who

see the great potentials that could be ahead for our profession if only more of our people were interested and wanted to be real family physicians.

Chiropractors have long had a paranoia about survival, which indicates an unconscious doubt about themselves. We need have no doubts about our survival as a profession as long as we are providing services which are really needed by the people in our society.

There has long been a trend in the medical profession to shun and G.P. and gravitate toward the specialties. This is creating an ever-increasing void in the field of general practice and the family physician, to a point today where it is the greatest unfilled need in health care services in our society. Why do chiropractors also follow the flight of the medical procession into musculo-skeletal specialties, when the urgent need for chiropractic family physicians is so urgent? With the high educational standards established by the Council on Chiropractic Education, and recognition by the national accrediting authorities, it is a natural and logical step for us to further elevate our profession to moving into this great field of urgent need.

Are we too complacent, too lazy to qualify ourselves, or too greedy for the quick buck? Maybe it is all three of these. I am grateful to all of you who have had the intelligence to perceive the great opportunities that could be achieved by chiropractors as family physicians and have qualified yourselves for a great service career. I pray that legions more will join with you before it is too late. □

— Ralph J. Martin, D.C.

THE PHYSICAL EXAMINATION

The physical examination performed by the Chiropractic Family Physician is unique in the field of health services. He not only is proficient in all the standard procedures relating to a medical physical examination but is also skilled in relating all the systems of the body to one another. He makes a distinction between the diseases of abnormal function and those of pathology. He has learned how to interpret surface findings on the body to internal disorders. He is very careful to get the patient's full history and relates the history and physical findings to guide him to determine the need for X-rays and Laboratory tests and profiles. Through his careful physical examination he usually knows where the problem is, then if tests are to be made they are for the purpose of evaluation of all physical and biochemical factors. By his very careful physical examination he is able to avoid many unnecessary laboratory and X-ray procedures which is a substantial economy to the patient and avoids excessive radiation. □

THE SYMBIOTIC RELATIONSHIP OF DENTISTRY, CHIROPRACTIC AND OSTEOPATHY

by Jere C. Butterworth, B.S., D.D.S.

The evolution of treatment of temporomandibular joint dysfunction has been, as with most disease processes, a clinical trial-and-error experience. There are numerous dissertations in the literature relating to differential diagnosis, treatment, terminology and classification of pathology related to TMJ dysfunction and myofacial pain syndrome.

The major thrust of this dissertation is to direct the attention of professionals to the concept that in many cases, temporomandibular joint dysfunction cannot be resolved without concomitant skeletal alignment. Clinical experience indeed indicates that almost always the most important single underlying condition related to TMJ and myofacial pain syndrome is skeletal misalignment. The three major misalignment factors are: 1) mandibular, 2) cranial, and 3) sacroiliac.

Unfortunately, dentistry is largely unaware that 1) the sutures connecting the various bones of the skull are *not* fused, and 2) there is a proprioceptive link between the TMJ and the S-I joint. Osteopathic and chiropractic literature is replete with related literature; dental literature is curiously void of reference to these two phenomena.

Primarily, there is great confusion in the selection of the modality of patient management related to the treatment of TMJ dysfunction and myofacial pain dysfunction. Each approach has as substantiation what appears to be significant statistical evidence supporting that treatment modality.

Unfortunately, most studies have not been able to take into account the adaptability of the host. This factor is subjective and may be impossible to measure. It is certainly necessary to consider the patient's adaptability to stress in gauging the positive or negative results of various treatment modalities. Many instructors in the field of treatment caution that "not everybody will respond to treatment." This is true in part, but to what degree is failure related to treatment accomplished without management of a skeletal misalignment?

It is the opinion of some practitioners that the greatest contributor to this margin of failure is the fact that many treatment modalities ignore or are unaware of the equal importance of cranial suture-jamming and sacroiliac misalignment.

In general, dentistry treats TMJ dysfunction, myofacial pain syndrome, headache and masticatory muscle pain as one or a combination of the following treatment modalities, in an order dependent upon their school of thought:

- 1) Mandibular repositioning splints
- 2) Psychological counseling
- 3) Occlusal equilibration
- 4) Biofeedback and self-hypnosis
- 5) Personal stress management
- 6) Electro-acuscope, acupuncture or acupressure
- 7) Drugs

Most authorities today feel that all of these factors should be considered and utilized dependent upon diagnosis and consequent treatment plans, and most schools of treatment are successful, to a point.

The pathology under examination here is stress related provided that stress is considered as any deviation of environmental force, both physiologically and psychologically for that particular individual. In other words, any physical or psychological aberration causing an imbalance in the homeostasis of the individual's normal functioning. Physical trauma, constitutional makeup or psychological state may all contribute to stress. This is an interactionist, or "biopsychosocial" approach to stress disorders.

One can, as an analogy, consider an eight-ounce glass as being the host's tolerance. Stress added in terms of ounces up to eight ounces can be tolerated; addition of more stress ounces triggers an acute episode. When almost any treatment is initiated, as delineated above, the patient responds favorably; that is, he is relieved of pain. In some cases the patient is then classified as "well." Keep in mind that in this disease as in many others, pain is the last thing to manifest itself and the first thing to disappear. Terminating treatment at this point is ignoring the major bulk of the dysfunction and leaves the disease process still intact, only to reoccur as environmental stress circumstances dictate.

A careful, in-depth history, especially related to trauma in the patient's past is invaluable, even if the trauma occurred ten to fifteen years earlier. Trauma, especially of the whiplash type, almost always indicates the need for cranial and/or sacroiliac alignment and stabilization. In cases of previous trauma, sometimes diagnosed as minor, in the preceding ten to fifteen years and where localized TMJ treatment has been successful in that the patient is free of most or all of the characteristic symptoms, reoccurrence of acute symptomology will occur.

Experience has shown that in every case of this type, either the S-I joint was misaligned or the cranial sutures were jammed. In some cases, both were involved. Once the skeletal system was aligned and the cranial sutures freed up, the patient's response to an orthopedic repositioning splint was immediate. Some practitioners feel that in many cases classified as treatment failures fall into the category of untreated skeletal misalignment.

On the other hand, it should be noted that if the mandible requires orthopedic repositioning in order to develop a balanced neuromuscular occlusal system, and this is not performed, then the skeletal system will not remain in balance. Continual skeletal and cranial adjustments will be required, most of which will not hold for more than a few days.

It is mandatory that dentists and physicians become aware of the need for chiropractic and osteopathic consultation, especially related to osteocranial and sacroiliac joint relation. They should begin to work closely together to resolve some of these cases classified as untreatable.

An example of a typical case history follows: The patient presented April 9, 1981 for initial TMJ consultation, upon referral from her chiropractor.



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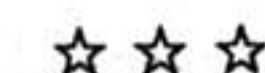
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(Continued from page 10)

History

- 1) A blow between the eyes by a black bear in 1976, with no significant medical consequences after momentary unconsciousness.
- 2) Extraction of upper and lower third molars in 1979 under general anesthesia.
- 3) Migraine-type headaches commencing in late 1976 or early 1977. (Term "migraine" was patient's diagnosis.)
- 4) Variation of headache which overlaid the migraine-type headache subsequent to extraction of third molars.

Symptoms

- 1) Migraine-type headache lasting three to ten days and causing complete debilitation.
- 2) Inability to move mandible through normal range. Maximum opening of 34mm.
- 3) Severe pain in right TMJ; pronounced audible click in both TMJ's. Patient unable to achieve work positions left or right without severe discomfort.

Muscle Examination

- 1) Right masseter slight tenderness at insertion
- 2) Right internal pterygoid mildly tender
- 3) Right external pterygoid extremely tender
- 4) Right sterno-cleido-mastoid tender at insertion
- 5) Right lateral and upper trapezius, moderately tender
- 6) Right posterior cervicals exquisitely tender
- 7) Right pectoral moderately tender
- 8) Right deltoid moderately tender

Supplemental Symptoms

- 1) Progressive numbness right arm
- 2) Slight enlargement right pupil
- 3) Distal superior position of condyles in their fossae, with the right condyle in a more distal position
- 4) Ringing in the ears
- 5) Dizziness

Treatment

On May 11, 1981 a mandibular orthopedic repositioning splint was placed with the aid of TENS (trans cutaneous electrical neural stimulation). Several hours later the patient developed a migraine-type headache which lasted for five days. This was followed by eight days of comfort. On May 21 the patient awoke with her teeth clenched (splint in place) and was unable to open her mouth. Ice packs for three hours relieved her spasm. Numbness of the right arm was no longer present. The external pterygoids were barely tender, with

somewhat more tenderness on the right side. All other muscles previously involved were normal. Electro-acuscope was applied to further relax pertinent musculature and to treat a primary headache.

On May 27 she presented with the right trapezius, sterno-cleido-mastoid, deltoid, pectoral and all muscles of mastication in acute spasm. The right pupil was completely dilated and patient was in acute discomfort. A TNS unit was applied to upper and lateral trapezius and ethyl chloride spray was applied to the involved muscles in an attempt to break the muscle spasms. Robaxin was administered P.O. in the amount of 750 mg. Patient was referred to an osteocraniologist for evaluation and treatment.

Consultation with the craniologist the following day revealed that all cranial bones around the right orbit were severely jammed. Primary effort to relieve jamming was marginally successful. Because the right eye remained fully dilated, patient was referred to a neurologist.

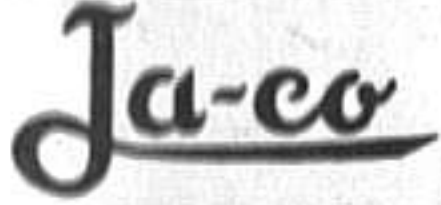
A full neurological workup including extensive radiographic examination and CAT scan revealed no demonstrable pathology.

Patient continued treatments with the craniologist, with gradual remission of symptoms recorded. Concomitantly, the orthopedic repositioning splint was readjusted with the aid of TENS.

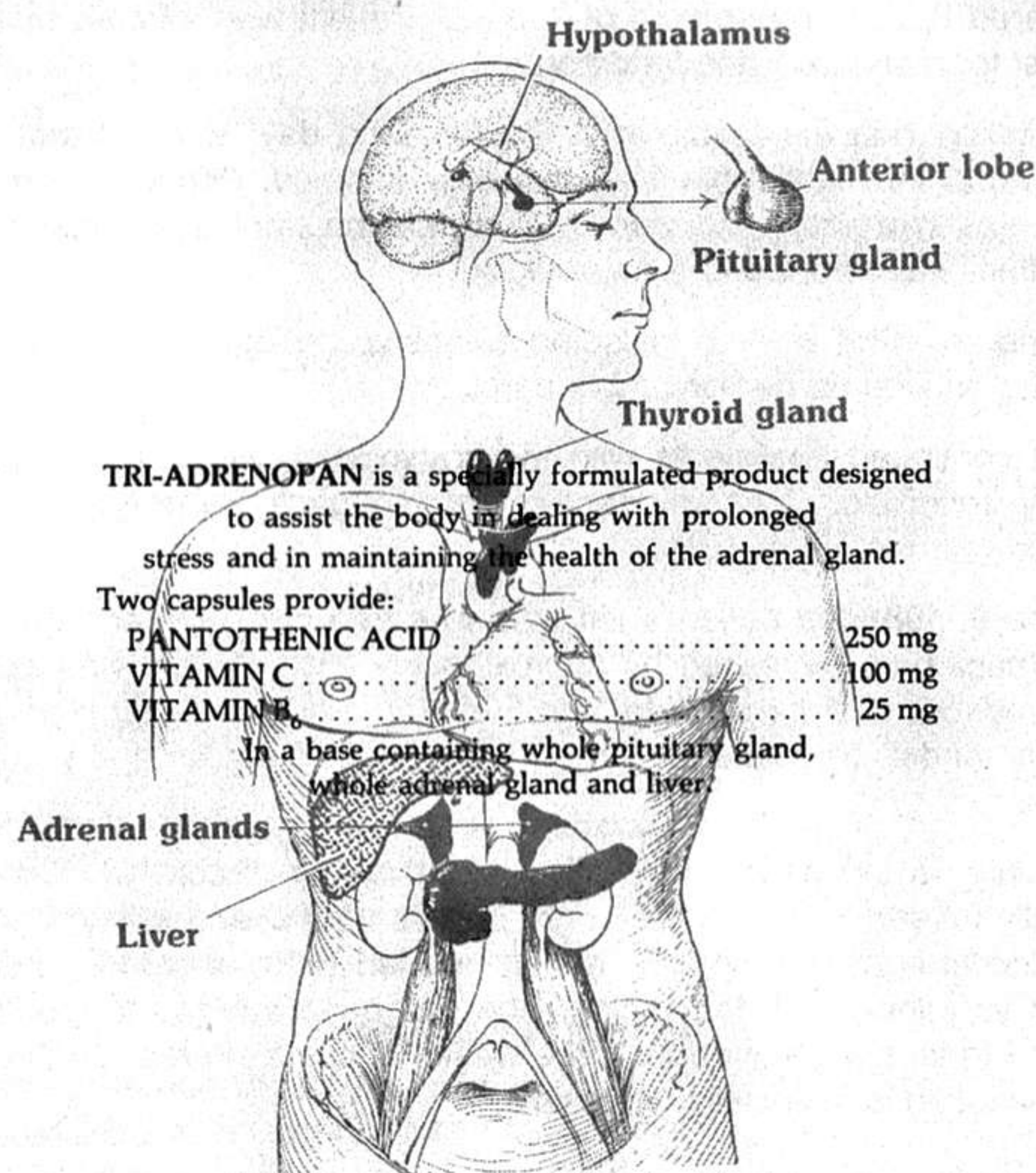
By June 9, 1981 the patient's left side was free of spasm and the dilation of the right pupil had decreased by approximately 25%. Patient was experiencing some numbness of the right side, and the internal and external pterygoids were exquisitely tender. She was placed on a course of Robaxin and prednisone for four days.

As of July 15 the patient is relatively free of any discomfort. The right side periodically reverts to spasm. The right pupil is normal and remains so. The patient's periodic right side spasms are associated with her working habits which are often very long and demanding. She has been advised to modify this behavior and to take a vacation for three weeks of complete rest. At this time, this recommendation is financially unfeasible.

(Continued on page 30)

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AN IDEA WHOSE TIME HAS COME

by Marvin S. Dayan, D.C.

(Continued from last issue)

If we are to continue our professional education and momentum, we must take positive action and disassociate ourselves from our professional brothers who personify the status quo. These are the same people who advocate eliminating diagnosis. This vacuous thinking separates the level of the profession from that of the technician, thereby reducing our profession to the level of the technician and thus not being recognized as a primary healing art.

Many years ago it took six months to earn a D.C. degree; now it takes six years. Chiropractic education is now almost equivalent to the medical doctor. We cannot demand this type of progressive education of the student, and at the same time restrict him to what we did many years ago. Since we demand this type of education, we must give the new doctor a full scope, with space, to practice the healing arts as a primary doctor. Only then will we gain the acceptance from the patient, the state and at the nation's capitol.

Today's education prepares us for this eventuality, but at present we do not have the legal mandate for this to come about. In this respect our profession is analogous to a kettle of boiling water, which has nowhere to expand and it ultimately blows its lid. With extensive education, and limited use, the student has a profound frustration which is unresolved.

What differentiates us from the medical doctor is our philosophy of natural healing. Progressive education leads us to a comprehensive service to meet the needs of our patients.

We, as a group, must be an alternative to medicine. It boils down to the essential simplicity, of natural healing versus synthetic medicine. The people have the right to make an independent and alternate choice.

Let us consider our title "an idea whose time has come".

We are actually speaking of our **professional survival!** If we follow the route of the "straight" jacketed practitioner, we are doomed to status quo and non growth. We are also doomed if a national health plan comes into being. It may seem that these two statements are in conflict with each other, not so . . . consider the word **limitation.**

The government requires that the primary health provider must be a physician. They do not see us in a primary role as a health provider. Therefore, we must do everything in our power to become a primary, sought after professional discipline.

Let us face reality! We are thinking of our professional survival! We cannot meet the unmet needs of the people for two visits a month, at (\$5.70) five dollars and seventy cents a visit.

Our scope of practice is limited as we are not paid for examination, x-rays or laboratory work. In the eyes of the government, and the straights, we are reduced to the level of a technician. Is this what we want? I need not tell you what a legal

CALCIUM, MAGNESIUM AND MUSCLE SPASMS

by John C. Lowe, M.A., D.C.

It's not unusual for a doctor to feel perplexed when he has used all his usual clinical tools and *still* a patient's muscle spasms won't release. In many cases, the spasms won't let go because the patient has too little calcium and/or magnesium in his system. These two nutritional deficiencies can induce spasms by heightening the excitability of nerves and muscles.

Spasms

It's important to relieve spasms promptly and completely. There are at least three reasons why:

First, visceral spasms can be highly inconvenient and distressing to patients. A couple of examples are spasms of the colon, which can lead to constipation and toxifying intestinal stasis, and spasms of the uterus, which can totally debilitate a woman.

Second, a spasm in virtually any muscle of the trunk can alter the normal dynamics of the spine. Consider, for example, that the right rhomboid is spastic, while the left rhomboid is normally toned. In this case, the upper thoracic spine may deviate to the right. Consider, too, that the multifidus on the right side of a vertebra is spastic. This may fix the vertebra in extension, rotation, or lateral flexion. These spinal disrelations may alter neural transmission from the involved spinal levels. In turn, this may compromise the functioning of the body parts innervated by these levels. In this way, a muscle spasm may disturb practically *any* part of the body.

Third, a spastic muscle can be a serious problem in itself. During a spasm, the pressure inside the muscle increases. The arteries, veins, and lymphatics coursing through the muscle are compressed. This may impede the flow of nutrients and oxygen into the muscle and the flow of wastes out. When muscle cells receive too little oxygen, the muscle becomes painful. When too little calcium and magnesium reach the cells, the muscle contracts even harder, further compressing its vessels. Moreover, when a muscle is spastic, its metabolic rate is increased. More wastes are then produced. But because its veins and lymphatics are compressed, the muscle may retain too much of the wastes. The wastes may poison the muscle, inflame it, and perpetuate the spasm.

Nutritional Therapy

Clinicians have used many *physical* procedures to relieve spasms. Some examples are fomentation, sine wave, diathermy, ultrasound, digital pressure, muscle stretching, and spinal manipulation. But many spasms, as I said, are caused largely by a calcium and/or magnesium deficiency — a *biochemical* matter. These spasms release *only temporarily* under the influence of *physical* procedures. The biochemical insufficiency *must* be corrected for lasting relief! Other spasms can be caused primarily by trauma, or perhaps by excess neural stimulation from a subluxation. Even with these, however, calcium and magnesium may enhance the antispasmodic effect of other procedures.

(Continued on page 20)

HEALTH SERVICES IN AMERICA

1. Diagnosis is the first step for a patient to enter into any phase of health service.
2. For this obvious reason Chiropractic Family Physicians must develop an image in the public mind of special expertise in diagnosis.
3. We already have a basis for this but it must be perfected and made known regarding our association of internal disorders. We have to stop only concerning ourselves with the structural problems.
4. In the field of therapeutics our graduates must be prepared to work in the field where there is the greatest need. This is the area of the Family Physician. Statistics clearly show the flight from "general practice" in the medical field. Practically all geographic areas are sadly lacking in "general family practitioners."
6. In this era of specialty proliferation the patient needs diagnosis first and, second, "someone who can put it all together" before he or she sees any specialist.
7. This is made to order for properly trained chiropractic family physicians and there are untold thousands of opportunities for chiropractic graduates who want to provide this broad scope of services.
8. Statistics on the overabundance of specialists and scarcity of general family practitioners are overwhelming.
9. The chiropractic family physician provides a unique and effective public service and does not need to prescribe drugs. When drugs or surgery are properly indicated by the diagnosis, he refers the patient for these services and builds a climate of cooperation and respect with the other health professionals. □

(Continued from page 18)

Both magnesium and calcium are to be administered. This may be confusing, for while magnesium triggers *relaxation* in muscles, calcium triggers *contractions*. It might seem that the appropriate approach is to administer large doses of magnesium and to intentionally induce a calcium deficiency. But this doesn't work. Paradoxically, when the calcium level falls too low, muscles don't relax — they become *spastic*, as in a magnesium deficiency. This is because calcium inhibits the flow of impulses over nerves. If calcium is *deficient*, nerves discharge too rapidly or continuously, exciting muscles excessively — even to the point of spasm.

It's important that the calcium and magnesium be administered in proper ratio: about one part calcium to two parts magnesium.

Vitamin D also should be administered. This vitamin is essential for transport of the minerals from the small intestine into the blood. Two to 3,000 units per day have been shown to produce distinct hypercalcemia, one effect of which is sluggish and weak muscles.

Caution should be used with vitamin D, since it may cause side effects in some patients. One hundred and fifty thousand units for 10 to 14 days have stimulated oxidation of body fats and deposition of calcium in aorta and kidney. This is a dosage *far* in excess of that a patient is likely to ingest daily. There is, however, the matter of *individual sensitivity*. Some patients, few as they may be, are likely to react to extremely *low* dosages — especially when taken over a period of weeks, since the vitamin is stored in fat and skeletal muscle when taken in excess of one's needs. Antioxidants such as selenium, vitamins C, A, and especially E have been demonstrated to block the damaging effects of vitamin D. It's not clear what dosages of these nutrients are effective, but significantly increasing the patient's intake while on vitamin D. It's not clear what dosages of these nutrients are effective, but significantly increasing the patient's intake while on vitamin D is probably a good idea.

Any *quality* brand of magnesium and calcium with vitamin D should work, as long as it makes its way from the intestinal lumen into the blood. If you're not sure the calcium and magnesium in a product cleaves at a neutral or slightly alkaline pH, administer hydrochloric acid or glutamic acid hydrochloride (as produced, for example, by Willner Chemists of New York) with the minerals. These acids should reduce the pH of the stomach low enough to cleave the minerals and allow them to absorb into the blood.

Magnese

Vitaminerals recently began marketing their new product called Magnese (VM No. 10). Magnese was carefully formulated as an antispasmodic. It is an excellent agent in that it meets the prerequisites as I've outlined them for nutritionally combating spasms. Two tablets contain 1,000 units of vitamin D; so, 4 to 6 tablets should produce marked hypercalcemia in most patients. The ratio of magnesium to calcium is correct: 500 mg. of magnesium to 250 mg. of calcium in each two tablets. And the minerals are in forms that easily cleave in the gastrointestinal tract. The magnesium is in the form of magnesium oxide. This form

cleaves even in water. The calcium is in the form of dicalcium phosphate. This form doesn't even require a moderate amount of hydrochloric acid to cleave. Thus, no acid supplement is necessary when Magnese is used. Most of my patients who have used Magnese report that it is an effective antispasmodic.

Physiotherapy

Nutrients in the blood can reach a target tissue *only* if the circulation to that tissue is adequate. Remember that spastic muscles compress vessels that pass through them. Because of this, whenever possible, the minerals, vitamin D, and an acid (or Magnese) should be used in conjunction with some form of physiotherapy. If the minerals are absorbed well, a spastic muscle (such as the myometrium of the uterus) generally responds within 20 minutes or so. If, then, you are going to use physiotherapy to increase the blood flow (with the calcium and magnesium) through a spastic muscle, the nutritional agents should be administered 20 to 30 minutes prior to administering the physiotherapy. Diathermy, ultrasound, sine wave, digital prodding, and negative galvanism all increase the flow of blood through spastic muscles. Obviously, one or more of these will be the therapy of choice, depending upon which muscles are spastic and the degree of spasticity.

Summary

- 1) Calcium and magnesium, combined with vitamin D and hydrochloric acid can help alleviate spasms;
- 2) Magnese, by Vitaminerals, is an excellent product for this purpose;
- 3) Antioxidants, especially vitamin E, should be administered to prevent possible deleterious effects from vitamin D in hypersensitive patients;
- 4) Antispasmodic nutritional agents work best when used with some form of physiotherapy that increases the blood supply to spastic muscles.

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by F. Joseph Montagna

Richard H. Tyler, D.C.

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SPEARS PAINLESS SYSTEM

by Leo Spears, D.C.

I'm a collector of old chiropractic, medical and health texts. Some date back over a hundred years. It would, therefore, seem less than fair to review something that is not only out of print, but is exceptionally hard to find.

In spite of this, I feel that reviewing some of our older pieces of literature is of value, if only to learn of where we came from so we might better decide where we want to go.

Actually, *Spears Painless System of Chiropractic and Other Developments* isn't that old with a copyright date of 1950. The book is of historic interest, however, because it espouses the philosophy of one of the pioneers of the profession. Flamboyant and fearless, Dr. Leo Spears probably made as many enemies as he did friends. I have the feeling, through his writings and actions, that this didn't mean much to him. After all, Spears Chiropractic Sanitarium and the Spears Chiropractic Hospital are monuments to his determined audacity in the face of medical pressure.

These characteristics are evident in his book which is filled with solid biomechanical concepts and with egotistical presumptions. An example of the latter is the title of one of the chapters, "Mysteries of Life Revealed" with the subheading reading "What 'Life' Is, Where It Comes From, How It Gets Into the Brain, How It Gets From the Brain to the Organs, and How the Tissue Cells Utilize It." That's a pretty big order for one chapter. The proof of all his ideas seems to be his "research" which we are apparently supposed to accept at face value. If only balancing the federal budget were as simple as explaining the mysteries of life.

With all its flaws, purchasing the book is still a worthwhile way to spend your time and money. You will be exposed to some excellent mechanical reasoning along with a good measure of unique philosophy. I suppose the best way to find out if the book is still to be had is to contact the Spears Hospital in Denver, Colorado. If you're lucky, you'll be able to put it in your library. ☐

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SPECIFIC NUTRITIONAL THERAPY

by Eve Campanelli, Ph.D.

Anemia is an insufficient replacement of red blood cells, and some signs of imbalance in this area are: intense fatigue, exaggerated stress reactions, heart pounding, etc. It seems to be most prevalent in women.

It is wise to have your patient avoid inorganic iron as it is constipating and hard on the body. To aid absorption and assimilation of the following iron rich foods and herbs, avoid the foods that "clog" the intestines, e.g. refined foods, red meats, pasteurized dairy products, sugar and salt.

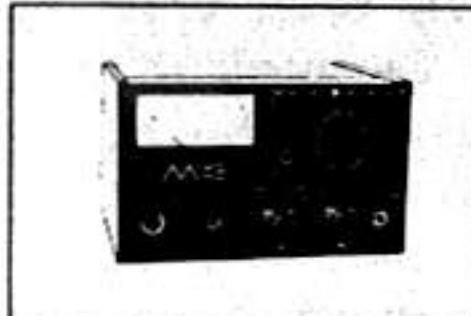
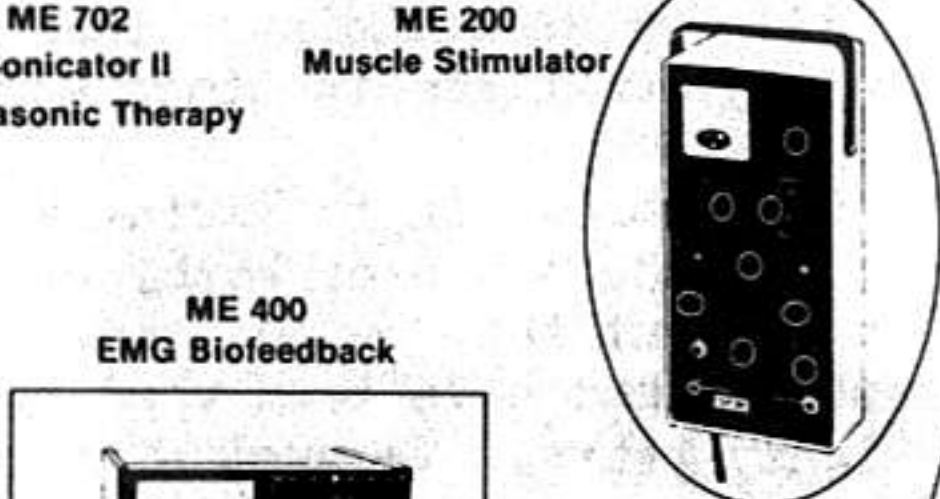
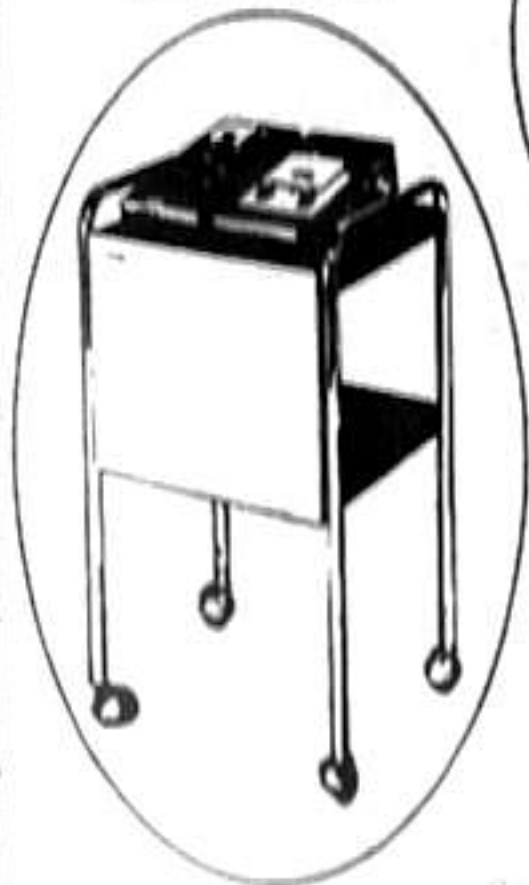
Herbs

Gentian two capsules 2 x a day for 1 week, then decrease to one capsule 2 x a day for a month, then maintain on one a day.

Yellow Dock rt. instructions as above. These two may also be combined with the addition of comfrey leaves which will make it even easier to digest. Use equal parts.

Foods

To a diet rich in green vegetables, fresh of course, and fresh fruits, whole grains and some fish, add specifically, dried apricots, raisins, prunes, peas, beans, leafy greens, sea vegetables and green apples. Avoid salt. ☐



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August 28, 1981

Dear Doctor:

Frankly, this is an appeal to ask you to renew your membership in our council! This may seem rather blunt but we need your support and covet your contribution to our cause.

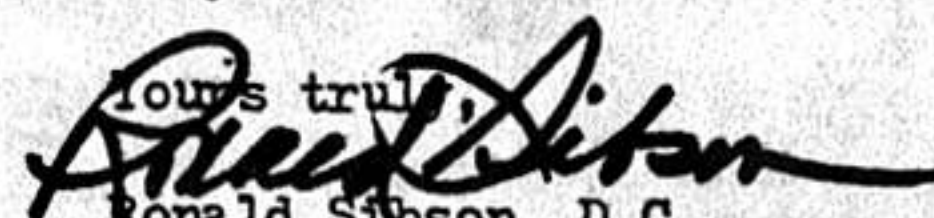
Briefly we are still working on our educational program which will lead to diplomate status and we have had much delay due to committee changes of the CCE. Nevertheless it does appear that the present committee will be more effective and that we will be having our program in action very soon. National and Logan Colleges to date have indicated their willingness to participate in the program.

Next we have an audio cassette program developing that will bring you up to date on NVD that will be available to those so interested. In addition, our Video tape program shows a lot of potential to those who find it difficult to get to seminars.

We are heading a educational seminar for 1982 under the direction of Dr. Robert Wiehe in association with the other specialty councils and we anticipate this to be concerned with material not readily available in other seminars.

Our profession is facing a surge of limited practice as evidenced in the state of Washington's recent law changes. We must act to prevent this by pointing out the need for use of all natural methods that have been used by chiropractors throughout the last eighty years. We must either advance to the status of full health providers or let the minority revert us to the level of a technician. Please think this possibility over!

Good news...you will be receiving a copy of the Chiropractic Family Physician soon. Let Dr. Nelson, our treasurer hear from you soon. His address is on the letterhead and the \$25.00 will more than appreciated. Thank you.

Yours truly,

Ronald Sibson, D.C.
President, CDID

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DISEASES OF ABNORMAL FUNCTION vs. DISEASES OF PATHOLOGY AND SEVERE TRAUMA

Ralph J. Martin, D.C.

The Dynamics of Correction of Abnormal Function constitutes a new functional physiology and has to be so recognized by the clinician in order to adjust the mind to the methodology that is involved. This distinction of diseases probably first propounded by T. J. Bennett in his book *"A New Clinical Approach to the Correction of Abnormal Function"* 1960, is possibly one of the most profound and even revolutionary concepts to come out in the field of health sciences in this century. While he made very little mention of the diseases of pathology and severe trauma, his very emphasis on the correction of abnormal function left an inevitable question — "What other diseases are there?" The answer seems to be: There are the diseases of pathology and severe trauma. This opens up the question of the relative frequency of these two main disease categories. Which one occurs most often? This concept is so new that no statistics on it are available, but from half a century of observation and clinical experience an educated guess would be at least 85 percent of ailments that bring people to doctors are diseases of abnormal function and this leaves between 15 - 20 percent for diseases of pathology and severe trauma.

This opens up a number of doors to be examined to see what lies behind them. Particularly these doors open into the sociology and economics of our society.

When patients come to most doctors and there is no evidence of pathologic disease or acute trauma, they are told that their trouble is all in their head or to go ahead and forget it, or take aspirin, and if the patients keep coming back, blindly seeking help they are, in desperation, referred to a psychiatrist. The other alternative is to put the frustrated patient on a Rx tranquilizer or a Rx pain killer. This way the patient is recovered for the medical profession and a possible long-time consumer of Rx drugs, and occasional office visits. Such doctors know they are not helping the patient, but their pursuit of relief from pain helps to pay the overhead and keeps up the volume of medical patients. What we have just said amounts to this: The medical profession is really doing nothing for patients suffering from the diseases of abnormal function whether they send them home to suffer in frustration, or keep them coming for Rx pain killers and tranquilizers. The sad fact is that more than three-fourths of the sufferers in our society are afflicted with the diseases of abnormal function.

With our present health care delivery system they are destined to be either totally neglected and made to feel "odd" or "peculiar" because they do not have a disease for which medical doctors can prescribe some specific drug. When they are not neglected they are taken for suckers and given Rx which are useless and accomplish nothing except to add to the profits of the medical industry. We contend that this is a serious sociological problem, using the

majority of people seeking health benefits to improve the cash flow of the medical professionals and hospitals when they know very well that they have nothing of benefit to offer the patients who suffer from diseases of abnormal function.

The multitude of diseases of abnormal function, such as hypoglycemia, functional hypothyroidism, inward goiter, etc., they do not want to recognize as diseases because they have no Rx for the benefit of such patients. Another reason for the medical practitioners' reluctance to recognize diseases of abnormal function is that they would be admitting that for generations they have been treating most of their patients with methods which are wrong and worthless for most of them. This brings up the economic issue. It is beyond calculation how many billions of dollars the public has been paying for medical services which are wrong, worthless and often fatal. There is no way these wrongs can be righted, but at least it certainly is long overdue that awareness and the light of reason and honesty be thrown upon such an horrendous practice by so many thousands of parasites. There is no prospect of any change in this situation until there is general recognition that diseases of abnormal function must be recognized as being just as important as the diseases of pathology and severe trauma and are actually far more prevalent. Furthermore, it must be recognized that diseases of abnormal function can be treated very successfully and usually quite economically. □

Editorial (Continued from page 6)

who supplicate themselves to a profession which teaches only 18 to 30 hours of X-ray — who bow to those who never studied a single thing on or about nutrition — who show respect for people who don't know the first thing about physical therapy and accept without question the efficacy of drug therapy as promulgated by those who may have had only 90 hours in pharmacology in medical school. I'm tired of those who think of themselves as second-class while having a first-class education. No finer physician exists than the modern chiropractor. It's time for us to assert the primacy of natural therapeutics and stop apologizing for what we are by allowing our concepts to be pillaged, vilified or stolen without defending ourselves.

In fact, it's time that we stopped being on the defensive and started attacking. The anti-trust suit was a noble but ill-prepared step in the right direction. The best way to fight an enemy, however, is to attack him where he lives, not in a court where our resident kooks can be dragged in front of a jury for public scrutiny. We're so used to the loons that we forget that the public isn't. People will forget the medical quacks, but with us the entire profession can be tainted by a single bad practitioner. This will probably change with time, but at present we must live with the reality of things as they are.

It's time that all the healing arts, other than the allopathic, assert themselves as primary physicians and portals of entry into the health systems of this country. If you are academically prepared to diagnose, then it is your duty to treat or refer. Isn't this, after all, what a primary physician is? Don't check with the AMA on this — they'll give you the wrong answer. □

Symbiotic Relationship (Continued from page 13)

Discussion

This case is somewhat atypical because of the severity of the discomfort, but it dramatically demonstrates the need for close cooperation between the dentist, the chiropractor (craniologist) and the physician. In this case, as in many, localized treatment by the dentist cannot obtain the desired result. The need for cranial adjustment is obvious for without cranial repositioning, positive and permanent results are not possible.

Prior to presentation at this facility, this patient had been classified as incurable for psychogenic reasons. Cooperation between dentists, chiropractors and osteopaths can rescue these patients from what is often years of pain and drug dependency.

Finally, the following points need to be made:

- 1) Orthopedic repositioning splints are not necessarily a part of each treatment.
- 2) Maxillo-mandibular vertical relationship is a prerequisite to diagnosis of splint therapy.
- 3) Upon acquisition of a stable physiological situation, a definitive treatment must be diagnosed and accomplished. Definitive treatment can be a) prosthetic (fixed or removable) b) orthodontic or c) a combination of prosthetics and orthodontics.
- 4) Only about 8% of mandibular misalignment cases can be resolved with occlusal equilibration.

Dr. Jere Butterworth is associated with the Calabasas Health Center, and is the coordinator of TMJ treatment. ☐



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